Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 1229 PAULINE MARGARET SORENSEN SLOAN August 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Union Memorial Hospital Baltimore City If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, May 11, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min 1 □ M 2 💢 F 217-26-5060 Director 85 1924 Maryland Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Show Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be realised at N/A 1 XYes 2 No Baltimore City Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4100 North Charles Street, #414 21218 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. <u>م</u> Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Agent permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Christian Peter Sorensen Frances Margaret Lucas ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marta H. Campbell (Daughter) 6203 Mossway, Baltimore, Maryland 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rose Hill Cemetery 8/27/2009 4 ☐ Donation 5 ☐ Other (Specify) Cumberland, Maryland 21. Signature of Funeral Service Lie isee MITCHELL-WIEDEFELD FUNERAL HOME, INC Martin D. Lawson 6500 York Road, Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Uear /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 5 Other (specify) signed by the a P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>چ</u> icate has been siç ; page 2 should b 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed Hospital or Attending Physician: The certificate Division of Vital 2 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Medical Certification: To this After thi funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 124 hours after death. • Funeral Director: A pletely filled in by the fu death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifiei 1🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. 29c. License number 29b. Signature and

State Registrar 30. Name and address of

DHMH 17 Rev 1/2001

ORIGINAL

person who completed cause of death (Item 23a) (Type, Print)

		-	For State Registrar	State	of Mar	yland / I		rtment of I tificate of I		and M		giene Reg. No	211	09	27002
			Decedent's Name (First, Middle)	, Last)							2. Date of De	ath			3. Time of Death
	Physicia Medic		ANNE BEVE	ERLY COO	KE SCE	HEFFENA	ACKE	CR.			Month Augus	t. 23	· 200	Year) 9	4:47 A M
->	Examin		4a. Facility Name (if not institution,					4b. City, Town, o	r Location	of Death			. County o	of Death	
1			GILCHRIST HOSE						vson				altin		County
	Funeral			6. Sex 1 ☐ M 2 🔯 I	7. Age (l	n yrs. last birt סכ	hday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th ly, Year)		Cour	place (State or Foreign ntry)
	Director		220-34-6536 Usual Residence of Decedent		<u> </u>	77	115.		<u> </u>	ــــــا	July 1	2, 1	L932L	Mar	-yland
200	show	o	10a. State 10b. County		1	0c. City, Towr	n or Loc	ation							10d. Inside City Limits
Mon	28a-f	Director	Maryland N/	'A		Ba	alti	more Cit	CV						1 Yes 2 □ No
÷ c	a or 2	Ö	10e. Street and Number					10f. Zip Code				10g. Citizen of What Cou			intry?
4	ns 23 must	Funeral	221 B East Nor					1	21212				<u>USA</u>	<u> </u>	
ţ0	riten		11. Marital Status1 ☐ Never Married 2 ☐ Marr	Armed	ecedent Eve Forces2		13. V	las Decedent of H Yes, specify Cub	lispanic Ori an, Mexicar	gin? (Spe n, Puerto I	cify Yes or No- Rican, etc.)			- Ameri	can Indian, etc.
936	al", o Exam	q p	3 ☐ Widowed 4 🕅 Divorced	If Yes, 0)	1	☐ Yes 2X No	Specify:				Specify:	Whi	te
Ŏ	natur lical l	lete	15. Deceden	it's Education		16a.		ent's Usual Occup				16b. K	(ind of Bu	siness Ir	ndustry
21215-0036	tal Hygene. state than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by	(Specify only higher Elementary/Seconday (0-12)		(1-4 or 5+)		life. DC	ind of work done NOT use retired,	during mos)	t of workii	ng				
2	ygien her ti	Be C					Car	e Giver	1						Services
and Sifter	rked other i	To B	17. Father's Name (First, Middle, L	,							(First, Middle,				Mollion
Specify: Where Married 2 Married 1 Yes 2 No Specify: Where I Yes 2 No Specify: Yes I Yes 2 No Specify: Where I Yes 2 No Specify: Yes I Yes 2 No Sp															
Z S	Addison Barnwell Cooke Hortense d'Aeauharnais 19a. Informant's Name/Relationship (Type, Print) Margaret R. Brown (Daughter) 18b. Mother's Name (First, Middle, Maiden Sumane) Hortense d'Aeauharnais 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2) 531 Overbrook Road, Baltimore, Maryland														
ē,	0 E 9		20a. Method of Disposition	wii (bat	1811001	20b. Place of	f Dispos	sition (Name of			ate				own, State
imo	nt: If		1 ☐ Burial 2 🂢 Cremation 4 ☐ Donation 5 ☐ Other (S	3 Removal fro	om State			atory or other pla		8/25	/2009	Rol	timo	~	Maryland
Baltimore,	Department of H Important: If ite any injury or oth		21. Signatura I Funzi I Serric	Allann		OLCCII	22	Name and Addre	ess of Facilit	V	DUNTED AT	Dai	CIIIOI		Marytaiki
m 8		. 5	Martin D. L	awson			165	Name and Addre TCHELL-W 00 York	Road.	ELU Bal	FUNERAL timore	. HO≀ Mai	ME, I	NC.	1212
			23a. Part 1. Enter the disease, or shock, or heart failure. List o	complications tha	at caused the	e death. Do n	not ente	r the mode of dyir	ng, such as	cardiac o	r respiratory ar	rest,	-)		Approximate Interval Between
- Pi	rysician/	1	Immediate Cause (Final disease or condition	· M	tast	atic 1	una	concu							Onset and Death
1	Medical xaminer	resulting in death) Due to (or as a consequence of):											0		
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ted	Insit	Examiner	Cause (Disease or linjury	-	(5		/-							-1	
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6876	ng ph as th	Med	IF FEMALE:												-
X th	ttendi or use	ian/	23b. Was decedent pregnant		ve Birth 2 (Fetal death		Ectopic pregnan	су			2.0	23d. Date Mon		very Day Year
Box	the a	ysic	1 Yes 2 No 9 Unknown	4 □ Pr 9 □ Ui		me of death	5 📖	Other (specify) _					WIOII	ш	Day Teal
that the	ed by detac	Completed by Physician/Me	Part II. Other significant conditio	ns contributing to	death but	not resulting i	in the ur	nderlying cause g	iven in Part	I.	23e. Did to	obacco	use contril	bute to t	the cause of death?
S, I	sign Id be	q p	CAD+HT	N							1 🗆	Yes 2	□ No	3 🗆 Pro	obably 4 Unknown
ord V reg	s beer shou	olete	Kichey to	macala	1						24a. Was		24b. W	ere auto	opsy findings available
Se la	te ha	шо	1000	V.Sp.					_		auto perfo 1 Yes	psy ormed?		eath?	ompletion of cause of
	rtifica ctor, p	BeC	25. Was case referred to medical examiner?					26. P	lace of Dea	th (Check		ZIZNI	0	res	2 110
VSIC	nis ce I direc	၉	1 🗌 Yes 2 🔼 No	Hospital:	☐ Inpatient	2 ☐ ER/Ou	utpatien	3 □ DOA Oth	ier: 4 🗆 Ni	ursing Ho	me 5 🗆 Resi	dence 6	other	(Specif	w Gilchnist
ָם ק <u>יין</u>	of Affer the Tunera	Certificate:	27. Manner of Death 1 Natural 5 □ Pending		te of injury o <i>nth, Day,</i> Y		Time of njury	28c. Inju	k?	- 1	28d. Describe I	now injur	y occurre	d	
SION	death	tific	2 Accident Investig	not be	ce of Injuny	- At home fa	rm etra		Yes 2	-	20f Logotion /	Stmot on	d Number	or Pur	of Pouto Number
										a noute Number,					
- Cospits	hours uneral	Medical		Physician: To the											
the H	nin 24 the Fu	Med		xaminer: On the t Nurse Practions											ause(s) and manner stated. stated.
٥	To CO		29b. Signature and title of certifier	4 .				29c. Licens							Day, Year)
			mari -		RNP				1919	14		1400	Just	24	2009
	LV		30. Name and address of person v	and C	ause of deat			lus St,	Tow	SUN.	MD	91	204		
	Stat Registra	e ir	31. Date filed (Month) Per Year)	2009 2	Hegistrar's		h	not de							
							100 D	760 0							

09-06452 Gilbert James S		ett Sta		Black Indelible I / Department of Certificate of	of Health an		łygiene	200	9 2700
Physici	an/	Registrar 1. Decedent's Name (First, Middl GILBERT JAMES		······································			2. Date of Dea	Reg. No. ath Day Year	3. Time of Death
Medical Exami	ner	4a. Facility Name (if not institution		r)	4b. City, Town, or	Location of Deat	Month August 18	8, 2009 4c. County of De	0800 hrs
		Patapsco River under		•	Baltimore C			N/A	
Funeral Director		5. Social Security Number 220-72-4605	6. Sex 7. A	ge (In yrs. last birthday) 49 Y	If Under 1 Year Months Day		n	irth(MM/DD/YYYY) 9.1 9, 1959	Birthplace (State or eign Country) MD .
ń		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Loc	ation				10d. Inside City Limits
d fee any			IMORE	,	NDALK				1 Yes 2 X No
ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	ountry?
the M 3a or 2		65 WISE AVEN	UE			21222		UNITED STA	ATES
her death wi	y Funeral	11. Marital Status 1 Never Married 2 X Ma 3 Widowed 4 Divi	1 Yes		Vas Decedent of Hi Yes, specify Cubar	n, Mexican, Puert		White, etc	erican Indian, Black, · /HITE
nours a	eted by	15. Decedent's Education (Spec		during	ent's Usual Occupa most of working life			16b. Kind of Busines	s/Industry
11215-0036 Id be filed within 72 hours af Aental Hygiene, arked other than "natural event, the Medical Examin	Complet	Elementary/Secondary (0-12)	College (1-4 o	r5+)] ~~~	END TECH	HNICIAN	,	AUTO	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	B	17. Father's Name (First, Middle, ARTHUR SENNETT				REGINA 1	McCORMI(
, MD 21 and 2 should ealth and Mc em 27 is ms	٩	19a. Informant's Name/Relations TAMMY SENNETT/						mber, City or Town, Sta MARYLAND	ate, Zip Code) 21222
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum		20a. Method of Disposition 1 Burial 2 X Cremation 4 Donation 5 Other Sp.			osition (Name of ce other place) CREMATORY	· 1	Date 20/2009	20c. Location - City GLEN BURN	or Town, State
Balti permit. Departr Import		21. Signature of Funeral Service			Name and Addres	O.		S. ZEILER &	-
Physician /Medical xaminer		23a. First Enter the Iseas failure. List only one succ Immediate Cause (Final disease or condition resulting in death)	each line.	d the death. Do not ente	r the mode of dying	, such as cardiac	or respiratory ar	rest, shock, or heart	Approximate Interval Between Onset and Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b. Due to (or as a con						
ecuted and transit		events resulting in death) Last	Due to (or as a con	sequence of):					
760, ficate be exe g physician a	edic	UNPENDED	AMENDED						
Box 68760, a death certificate be the attending physic and for use as the burned for use	sician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	e 1 Live birth 4 Pregnant	at time of death	Fetal death 3 Other (Specify)	Ectopic pregr	nancy	23d. Date of deliv Month	ery Day Year
b. Bo the deat	Phy	Part II. Other significant conditi	Olikilowii	ath but not resulting in the	underlying cause	niven in Part I	23e Did 1	tobacco use contribute	to the cause of death?
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be execut within 24 hours after death. To the Functral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - train	Completed by						1 Ye	es 2 No 3 P	autopsy findings available o completion of cause of
tal Rectian: The l	히					·	1 🗸 Yes		
ital I sician: is certifi irector,	a	25. Was case referred to medical examiner?	Hospital: []	ient 2 ER/Outpatie	6-1	Other	k only one)	Residence 6 🗸 Otl	her: Scene
n of Vi ding Physi 1. After this funeral dir	12	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Ir	jury 28b. Time o		ıry at Work?	28d. Describe	how injury occurred	
Division of Vital Records, tal or Attending Physician: The law requir is after death. al Director: After this certificate has been siled in by the funeral director, page 2 should t	rtification:	- [2	stigation 28e Place of	0907 hrs Injury - At home, farm, str		Yes 2 ✓ No building, etc.		nped from Key bri	idge Rural Route Number, City
Divis Hospital or A 24 hours after Funeral Dire	ပီ	4 Homicide deter	d not be (Specify) R		turred at the time	ate and place	or Town, Center Span	State) Key Bridge, Baltimo	ore, MD
To the Hos within 24 h To the Fur completely	Medical	(Check only Certifying Pi	miner:On the basis of ex	my knowledge, death occ amination and/or investig					
F 2 5 8	Me	29b. Signature and title of certifie	and manner states		29c. Licens	se number		29d. Date signed (#	Month, Day, Year)
		ader	MI	7	O.C.	M.E.		August 19, 200	9
12 ,		30. Name and address of person	•	, ,	on Street Bal	timore MD 2	1201		

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Registrar

State 31. Date filed (Month,-Day, Year)

Division of Vital Records, P. 24 hours after death Fo the Funeral Director:

ve. residence Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) August 19, 2009 O.C.M.E.

30. Name and address of person who completed cause of death (Item 23a)

111 Penn Street, Baltimore, MD 21201 Russell Alexander MD. Assistant Medical Examiner

31. Date filed (Month, Day, Year) State

32. Registrar's Signature ORIGINAL

Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 12:50 P^M 2009 August Mano Swartz /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Greater Baltimore Medical Center Towson If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 X M 2 □ F 87 March 28. Maryland 056-16-1630 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10b. County show r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be nottiled at 1 ☐Yes 2 X No Towson Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21204 615 Chestnut Avenue, #1311 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 11 Marital Status 1 Never Married 2 Married 1 □Yes 2**X** No Specify White 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n any injury or other traumatic event, I'm Medione. Elementary/Secondary (0-12) College (1-4or 5+) 5+ Fur Furrier 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lora Wilfson James M. Swartz 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 615 Chestnut Avenue, #1311, Towson, Maryland 21204 Ida E. Swartz / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Hunt Valley, Maryland 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Swartz Family Cemetery 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Maryland 21204 21. Signature of Funeral Service Licenses 1050 York Road, Towson, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) hemorphagic bours **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Month Year Day 5 Other (specify) ☐Yes 2 ☐No the 9 Unknown á been signed b should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 ☐Yes 2 No certificate 1 ☐ Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 1 Tes this s after death.
I Director: After this
of in by the funeral d 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death (Month, Day, Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

29b. Signature and title of certifier

Name and address of MIN 31. Date filed (Month

person who completed cause of death (Item 23a) (Type, Print)

29c. License numbe

29d. Date signed (Month, Day, Year)

		-	State of Maryland / Depa State Cer	artment of Health and N Artificate of Death		ene g. No. 2009 27005
			Decedent's Name (First, Middle, Last)		Date of Death Month	Day Voor
	Physicia /Medic		USIA012 MAINIM		720304	19,2009 1:34 PM
The same	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death ANN ARUNDEL
	-		But hore-washington Hesical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	
	Funeral Director		5. Social Security Number 6. Sex 1 \times M 2 \times F 7. Age (In yrs. last birthday) Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Feb. 24	, 1930 New York
	g > 0		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	cation		10d. Inside City Limits
	f show	or	1.1.0			1 □Yes 24 No
	the N	irect	Maryland Anne Arundel Co. Severn 10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?
	th with	al D	7865 Cypress Landing Road	21144		United States
	be filed within 72 hours after death with the Maryland Hygiene. ad other than "natural", or items 23a or 28a-f show other than "natural", or items 24a or 28a-f show event, If the Marilest Expanity of mast be notified at	Funeral Director		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
20	rs afte I", or i	by F	1 □ Never Married 2 ፟ Married 1 Ĭ Yes 2 □ No If Yes, Give Year or Dates: Korea	1 ☐Yes 2X No Specify:		Specify: White
0500-GI	2 hour		15 December 5 Education 16a Dece	dent's Usual Occupation	rina l	16b. Kind of Business/Industry
2	thin 7; ie.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of work DO NOT use retired)	9	Business
A	filed wi Hygier other th ent, If u		17. Father's Name (First, Middle, Last)	Owner 18. Mother's Nam	e (First, Middle, N	Equipment Aaiden Surname)
/land	ld be fil lental H ked ot ic ever	Be C	Clayton William Stoffel	Doris	Dubray	
2	2 should be and Mental is marked or raumatic ev	ဍ		ng Address (Street and Number or Ru	rai Route Number	, City or Town, State, Zip Code)
, Mai	and 2 salth a 1 27 is er tra			Cypress Landing		vern, MD 21144
altimore,	les 1 a		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	matory or other place)		20c. Location - City or Town, State
	t. Pag rtment rtant:		4□Donation 5□Other (Specify) Atlantic			Glen Burnie, Maryland Funeral & Cremation
g	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic es <u>once</u> .	1				Glen Burnie, MD 21061
			23a. Part 1. Enter the disease, or c implications that caused the death. Do not en shock, or heart failure. List only one cause on each line.			est, Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):			V 6840
	LXammer	Ē	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):	I PRICICE COLLTIS		24AQ Y
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.			
Ç	e exec ian an ırial-tr		resulting in death) Last Due to (or as a consequence of):			
8760,	cate be executed physician and the burial-transit	dical	d			
ž 6	ding se as	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23c. If yes, outcome 23c. If yes			23d. Date of delivery
Box	00	Physician/Me	Live birtin 2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)		Month Day Year
<u>Ч</u>	the ache	hys	9 🗆 Unknown	underkijna sousa aivan in Part I	23e Did to	bacco use contribute to the cause of death?
Ś	res that signed to be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Fair i.		es 2 No 3 Probably 4 Unknown
Š	w requires been sign should be	eted			24a. Was a	an 24b. Were autopsy findings available
Vital Records,	The law cate has page 2 t	Completed			autop perfor 1 □ Yes	
a		Be Co	25. Was case referred to medical	26. Place of Dea	ath (Check only or	
	dii d		examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient			ence 6 Other (Specify)
Division of	ing Affe une	ion:	27. Manner of Death 1 Katural 5 ☐ Pending (Month, Day, Year) 28b. Time Injury		28d. Describe h	ow injury occurred
Sic	Attending or death. ector: After by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		28f. Location (S	Street and Number or Rural Route Number,
<u>~</u>	al or A s after il Dire ed in b	Certification: To			City or Tow	
	To the Hospital or Attend within 24 hours after death To the Funeral Director: , completely filled in by the f		29a. Certifier (Check only (C	ath occurred at the time, date and plac investigation, in my opinion, death occ	e, and due to the urred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)
	the P thin 24 the F mplet	Medical	one) and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)
	5 × 6 0	-	Sui toma se Campres Ho	P00 E3+1A	1	406057 19, 2009
	10x1		30. Name and address of person who completed cause of death (Item 23a) (Type			
	[∨ √		GUILLERHO JOSE GIANGRECO 301		GCEH B	NENIE HD 21061
	St Regist	ate	31. Date filed (Month, Day, Year) 32. Registror's Signature 32. Registror's Signature 32. Registror's Signature 33. Registror's Signature 34. Regist	barker		
			- LUUJ Comment	N. P. C.		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Day Month 1205 PM 2009 Charles Α. Serio 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Rosedale Baltimore FRANKLIN Square Hospital Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Dec . 1 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Year) 929 Days Hours Months 1**√** M 2□ F MD 212-28-2772 79 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 TVNo Rosedale Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 2234 Hamiltowne Circle 21237 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 2√2 No Specify: White 3 □ Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Poultry Distributor 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Josephine Serio August Serio 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2234 Hamiltowne Circle Rosedale MD 21237 Darryl Serio /son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Woodlawn Cemetery 8/22/09 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto 21221 Calit Connelly Funeral Home of Essex 23a. Part 1! Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on a child. Immediate Cause (Final letasta disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Month Day 5 Other (specify) ☐Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autops, performed: 2 XINo 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Completed by Funeral

Be

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f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Eventies of sust by multipolat

1 and 2 should be 1 Health and Mental

item 27

permit. Pages 1 Department of It Important: If ite any injury or ot

Maryland 21215-0036

Baltimore,

burial-transit and been signed by the attending physician should be detached for use as the buria has certificate

Hospital or Attending Physician: The law requires that the death certificate be executed

the

P.O. Box 68760,

Division of Vital Records,

Examiner Physician/Medical Completed by within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be Medical Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

5 Pending investigation 6 ☐ Could not be

determined

28a. Date of Injury (Month, Day, Year) 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

📂 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

1 Natural

2 Accident

3 ☐ Suicide

29a, Certifier

4 | Homicide

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and add

ess of person who completed cause of death (Item 23a) (Type, Print)

9000 Fran

State Registrar

32. Registrar's Signature Year) AUG 2 4 2909

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Harry T. Smith tugust /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ROSe 8. Date of Birth (Month, Day, Year)
Oct. 24, 1930 Birthplace (State or Foreign Country) Year If Under Number In yrs. last birthday **Funeral** Months Days Hours Min. 1 M 2 □ F 217-26-0087 78 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland I Hygiene. other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f should be modified at 1 ☐ Yes 2 ☐ No MD Baltimore Essex Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number USA 21221 5 Debkay Court Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2K Married Smith, Harry Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🛛 No Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Driver Sanitation permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien Important: If item 27 is marked other the any Injury or other traumatic event, Ins.) once. 6th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Glen Smith Ethel Cooper ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ella Smith /wife Dabkay Court Baltimore MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place)

Bayview Crematory 8/24/09 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signatury of Funeral Service Licenses Essex 21221 Connelly Funeral Home of 23a. Part 1. Enter the disease, or complications that caused the detth. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) /Medical perso (or as a consequence of) Examiner umonio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the as attending properties of 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) ☐Yes 2☐No certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 10 autopsy performe 1 ☐Yes 2 ☐ No 1 ☐Yes 2 No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation n 24 hours after death.

le Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide TS Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Might Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hor To the Fune completely fi (Check only and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00069529 20,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 9000

allen

HO Year

d (Month, Day, Year) AUG 2 4 2009 Franklin

Square Drive Baltimore MD, 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene.

			- For Amend Item 26 per verb., g89	Certificate of Death		g. No. 2 0 0 9	27009
	Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
×	/Medic	al	Charlotte Leona Shook 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	08	14 2009 4c. County of Deat	9 1527
	Examin	er	WMHS-BRADDOCK CAMPUS	CUMBERLAND		ALLEGANY	
	Funeral Director		5. Social Security Number 214-46-2932 6. Sex 1	irthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Jan 17,	Year) 9. Birt Co 1947 Mary	hplace (State or Foreign untry) Land
	and and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tox	wn or Location			10d. Inside City Limits
	Marylan I-f show Iled at	tor	MD Allegany Cumber	rland			1 ∐Yes 2X No
	th the or 28a	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	untry?
	ath wi		901 Seton Drive	21502		JSA	-to-a tradica
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 Is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the "Modeal Exercitive must be nuffled at	by Funeral	11. Marital Status 1 □ Never Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ☒ No Specify:	ecity Yes of No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
5-0	72 ho 'natur	eted	15. Decedent's Education (Specify only highest grade completed)	a. Decedent's Usual Occupation (Give kind of work done during most of work	ing	6b. Kind of Business/	Industry
121	filed within Hygiene. other than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)		food indus	trv
	filed Hygi other ent,	Be Co	17. Father's Name (First, Middle, Last) unk	# - • • · · · · · · · · · · · · · · · · ·	e (First, Middle, M		
/lan	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, In Mental Aumat	To B		Ruth Bert	ha Niner		
Maryland	2 should and Mer Is marke raumatic	ľ	The state of the s	b. Mailing Address (Street and Number or Rui		•	Zip Code)
	1 and 2 Health em 27 I			5929 Foundry Row; Mt.		MD 21343	Town, State
Baltimore,	Pa mer ury		4 ☑ Donation 5 ☑ Other (Specify)	of Disposition (Name of ery, crematory or other place) 22. Name and Address of Facility			-
Ba	permit. Departi Imports any Inj		21. John Funeral Service Licensee Ronal S. Wada Director	State Anatomy Board Baltimore, Maryland	L 21201		
	Physician /Medical Examiner		23a. Rart 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each immediate ause (Final disease or condition resulting in death) a. Due to (or as a conservence)	To Discontinuation	or respiratory arre	st,	Approximate Interval Between Onset and Death
	scuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence)				
68760,	ificate be executed g physician and as the burial-transit	edical Ex	resulting in death) Last Due to (or as a consequence d	e of):			
O. Box	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	F FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of de ath			23d. Date of de Month	livery Day Year
rds, P.	quires that en signed b uld be deta	Ď	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I. The Se Do Nettes Me	23e. Did tob	acco use contribute to	o the cause of death?
of Vital Records	The law re cate has be page 2 sho	Completed	Dickte Nephrapatry, Vol	une off food	24a. Was ar autopsy perform 1 □ Yes 2	ned#? death?	utopsy findings available completion of cause of
Vita	certific	Be	25. Was case referred to medical examiner?	Othor	th (Check only one		
o	Physer this eral dir	. To	27. Marginer of Death 28a. Date of Injury 28b	Time of 28c. Injury at	ome 5 Reside 28d. Describe ho	nce 6 Other (Spe w injury occurred	ecify)
ion	Attending in death. ector: After by the funer	atior	1 Natural 5 □ Pending (Month, Day, Year) 2 □ Accident investigation	Injury Work? M 1 ☐ Yes 2 ☐ No			
Division	al or Attencs after death	Certification: To	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (Sti City or Town	reet and Number or R , State)	ural Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination and manner stated.	lge, death occurred at the time, date and place and/or investigation, in my opinion, death occu	e, and due to the carred at the time, da	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	vithi To th	Ž	29b. Signature and title of contifier	29c. License number	29	9d. Date signed (Mon	th, Day, Year)
			11.Hilmila	017318		117 131	215
_			30. Name and address of person and completed cause of death (Item 23) OR . NAGO rath Routh 31. Date filed (Morth, Day, Year) 82. Registrar & fignature	a) (Type, Print)	ROAd,	Cumberle	2009, 21500 2nd, MD
	Sta Registi		ALIG 2.4 2009	barked			

DHMH 17 Rev 1/2001 ___

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death **Physician** gene da /Medical 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner dallstown If Under 1 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months **1** M 2 □ F Yrs 70 Director 147-22-0666 30 NJ Usual Residence of Decedent 10a State 10c. City. Town or Location 10d. Inside City Limits Hygiene. other than "natural" or items 23a or 28a-f show ent, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MD Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 317 Bonnie Meadow Circle 21136 U.S.A. by Funeral and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify. Specify: Black 3 XWidowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore County College (1-4or 5+) 5yrs+ Elementary/Secondary (0-12) 12th grade Administration School System ulth and Mental Hygie 27 is marked other if traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ressie Edmonds Eugene Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

or 317 Bonnie Meadow Circle, Reisterstown 19a. Informant's Name/Relationship (Type. Print) Health a Department of Health Important: If item 27 any injury or other troonce. Marinda Thomas Evans-Daughter 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory Inc 8/20/09 Baltimore, Md Metro 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licensee 4300 Wabash Ave, Baltimore, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or requires that the death certificate be executed pertens physician and s the burial-trans Due to (or as a consequence of) Box 68760. Physician/Medical as IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? ō Month Year Day 5 Other (specify) P.O. ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No autopsy certificate 1∐ Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 은 1 ☐ Yes Other: 1 🗌 Inpatient 2 ER/Outpatient this 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Medical Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation within 24 hours af er deain.

To the Funeral Director Aff 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) the and manner stated. 29b. Signature and title of certifier 29c. License number 241 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

2009

AUGUST

RICHARD THOMAS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 5:01 PM **Physician** 2009 Urbanowski Anna /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Johns Hopkins Bayview Medica Baltimore 8. Date of Birth (Month, Day, Year) 11-19-1924 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 6 Sex 5. Social Security Number **Funeral** Months Min. Davs Hours 1 □ M 2 X F Maryland 84 218-18-0411 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland nd Mental Hygiene.

marked other than "natural" or when the marked other than "natural" or when the man "natural" or when "natural" or when "natural" or when "natur 10d. Inside City Limits 10c. City, Town or Location 10a. State d other than "natural", or items 23a or 28a-f show event, the "Motical Examirer must be notified at 1XYes 2 No Director MD N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21224 USA South East Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. Specify: White ≥ 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) N/A Fox Chevrolet Finance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fil h and Mental H r is marked ott Be Katherine Busch Benjamin H. Smith ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is rr any Injury or other traum Once. S. East Avenue Baltimore, MD 21224 Andrew Urbanowski -Son 104 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 8-22-09 Glen Burnie, MD 4 □ Donation 5 □ Other (Specify) Cedar Hill Cem. 22. Name and Address of Facility Kaczorowski Funeral Home, 1201 Dundalk Avenue Baltimore, MD 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Bowel perf Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Metastatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760, Physician/Medical as attending properties as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No P.0. ed by the detached i 9 T Unknown 23e. Did tobacco use contribute to the cause of death? cate has been signed. page 2 should be dete Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate | 1 ☐ Yes 2 MNo 1 ☐Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To After this 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A investigation 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2009 RES-000

State Registrar 600

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Wolfe St

Baltimore, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, I

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 11:45 A M Andrew J. Womack, Sr. August 20, 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Columbia Howard Brighton Gardens of Columbia Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**X** M 2□ F 88 10-07-1920 Kentucky 283-14-2607 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2 📉 No Director Howard Columbia 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21045 United States 7110 Minstrel Way # 133 Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1X1Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2**X** No Specify: þ 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) B & O Railroad Engineer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sidney Belle Sexton ပ Lewis P. Womack 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4507 Cumberland Ave. Chevy Chase, Maryland 20815 Victoria W. Frink / Daughter item 27 other t 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 🌠 Cremation 3 ☐ Removal from State permit. Pages Department o Important: If any Injury or ± ŏ Arundel Crematory 08-24-2009 4 □ Donation 5 □ Other (Specify) Odenton, Maryland 21. Signature of u eral Service Lio ns 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road, Odenton, Maryland 21113 t1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ARDIO 8 Immediate Cause (Final حلح Physician ulkowar resulting in death) /Medical Due to (or as a consequence of): Examiner DISPARE HEITER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and I be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctonic pregnancy Month in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autops, performed? vas 2 No r this certificate has 2 No 1 Yes 1 Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Assista Other: 4 Nursing Home 5 Residence 6 Other (Specify) Living 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) After thi 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manper of Death Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. after death Director: d in by the f 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide n 24 hours at le Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ٥ 20 2009 30469 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AL G-VELLANK 8850 COLUMISM 100 PARKUNY + 308. COLUMBIA MD. 21045 8850 B-VELLANKI, 31. Date filed (Month, Day, Year) 32. Registrer's Signature --State Registrar

Certificate of Death

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year Kevin Wade 1750PM August 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** JOHNS HOPKINS BAYVIEW MEDICALCENTER Ballimore If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, 9. Birthplace Country) 7. Age (In yrs. last birthday) **Funeral** Hours Months Days Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show MD Director Himore 1 XYes 2 ☐ No 10f. Zin Code 10g. Citizen of What Country? USA items 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 0 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 Ď Divorced Specify: Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 7 is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled 17. Father's Name (First Middle, Be 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ permit. Pages 1 and 2 shoul Department of Health and Mi Important: If item 27 is mark any Injury or other traumati once. 19b. Mailing Address (Street and Number or Baltimore Maryland
Date 20c. Location - City or Town, State Krother Roundhill Road 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of proposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Baltimore, Md. 2122 23a. Part 1. Enter the disease, or com shock, or heart failure. List only or complications that caused the death. Do not enter be mode of dying, ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 20 days Inmourebel disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1∐Yes 2∭No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28h. Time of After 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 🗆 No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

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August 18, 2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 10e per fh g894 8-24-09 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2009 Month **Physician** 10:31AM M August 16, John Eldredge Wilbur /Medical 4b. City, Town, or Location of Death 4c. County of Death Aa. Facility Name (If not institution, give street and number) Examiner Baltimore Reisterstown 111 Delight Road 8. Date of Birth (Month, Day, Jan. 9, Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** 1**X** M 2□ F 1942 Maryland 136-34-8629 67 Director Usual Residence of Decedent 10d Inside City Limits death with the Maryland 10c. City, Town or Location 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatih and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar in that he notified at 1 ☐Yes 2 No Director Reisterstown Maryland Baltimore 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number **United States** lll Delight Rd. 21136 Delight Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 □ Yes 2 N No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No ð 3 ☐ Widowed 4 Divorced Completed 16b Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Episcopal Church Priest 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marjorie Creighton Harper Arnold Jackson Wilbur 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Delight Road Reisterstown, MD 21136 Mahartney F. Strickland, Jr. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Carroll Cremation Ser. 8-18-2009 Hampstead, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 11824 Reisterstown Road 22. Name and Address of Facility 21. Signature of Funeral Service Licensee ELINE FUENRAL HOME Reisterstown, MD 21136 J. Wayne Osterling 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) attending physician for use as the buria Division of Vital Records, P.O. Box 68760, Physician/Medical If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗌 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did toba o use contribute to the cause of death? 2 1 V es 2 🗌 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 📑 Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) Hospital: 2 🗖 No 1 ☐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To this filled in by the funeral 27. Manne of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of after death. 28c. Injury at Work? atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 □ Could not be 3 Suicide 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Schraed 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

ORIGINAL

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month A^{M} 0715 **Physician** August 15 2009 Lloyd Alan Anderson, Sr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Cecil Rising Sun
If Under 1 Year If Under 24 Hrs. Calvert Manor Health Care Center 8. Date of Birth (Month, Day, Year) JAN 3, 192 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Hours Months Days Wisconsin 1926 83 394-20-7180 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State t be notified at 10b. County 1 ☐ Yes 2 No Director Rising Sun Maryland Cecil 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21911 United States or items 23a 1881 Telegraph Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? World 1 M Yes 2 □ No If Yes, Give Year or Dates: War I 14. Race - American Indian, Black, White, etc. is 1 and 2 should be filed within 72 hours after d
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other traumatic event, the Medical Examiner. 2 should be filed within 72 hours after and Mental Hygiene.

is marked other than "natural", or ite 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Specify: Saltimore, Maryland 21215-0036 Specify: War II þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Social Services Director Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Wicklund Ferdinand Alexander Anderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 114 Brantwood Drive, Elkton, MD Carol L. Anderson/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If iter
any injury or ott August 18, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State West Chester, PA 4 □ Donation 5 □ Other (Specify) R. A. Ferris & Co., Inc. 2009 22. Name and Address of Facility Hicks Home for Funerals, 103 W. Stockton Street, 21. Signal re of Funeral Service Licensee P.A. 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cerebral Vascular J was Ks Physician /Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to the as a consequence of attending physician and for use as the burial-transit The law requires that the death certificate be executed Box 68760, 💉 Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Alzheimer Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2/10-No 1□ Yes 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation s after death. 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide filled in by 4 Homicide 1 Secritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hor To the Fune completely fi (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified D002832 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Way Rising LATTIN COLONIAL 31. Date filed (Month, Day, Year) AUG 24 State railed Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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Physician
/Medical
Examiner

Funeral Director

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ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examinal rough be notified at

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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ne law requires mat e has been signed b ge 2 should be deta	Be Completed by Ph	Part il. Other sign
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nysician: nis certific director,	To Be	25. Was case refe examiner? 1 ☐ Yes 2 [
o the hospital of Attending Physician; The law requires that the obeain ce within 24 hours after death. To the Luneral Director: After this certificate has been signed by the attendi completely filled in by the funeral director, page 2 should be detached for use	Medical Certification: To	27. Manner of Dea 1 Natural 2 Accident 3 Suicide 4 Homicide
lo the Hospital within 24 hours a To the Funeral C completely filled	edical	29a. Certifier (Check only one)
Vith Con E	Σ	29b. Signature an
		30. Name and add
Bb		Philip W

		For State Registrar			•	tificate of	Death	Reg	. No.	2/010			
hysici	an	1. Decedent's Name (First, Middle, La						2. Date of Death Month	7, 2009 Year	3. Time of Death 10:00 A M			
/Medic	cal	Mildred Shea 4a. Facility Name (If not institution, gi	Barbour	-1	T	4h City Town	or Location of Death	August 0	4c. County of De				
Examir	ier	Genesis of Walfo		,		Waldo	_		Charles				
ineral rector		Social Security Number 6.	Sex 7. A	ge (In yrs. last b 91	birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Y Sept 3,	9. B 1917 Ma	irthplace (State or Foreign Country) ryland			
>		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	ation				10d. Inside City Limits			
f sho	ō	MD P.G.		,		e Hills				1 □Yes 2√XNo			
-28a-	Director	10e. Street and Number			- CP	10f. Zip Code	Zip Code 10g. Citizen of What Country?						
23a or	al D	2912 Oxon Par	k Street				20748		United States				
sme	Funeral	11. Marital Status	12. Was Deceden Armed Forces		13. V	Vas Decedent of Yes, specify Cub	Hispanic Origin? (Spetan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	nerican Indian, ite, etc.			
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Expresser must be notified at once.	by	1 ☐ Never Married 2 ☐ Married 3XXWidowed 4 ☐ Divorced	1 ∐Yes 2∏ If Yes, Give Year or Dates	:	1 ☐ Yes TX No Specify:		Specify:		Specify:	White			
"nati	Completed	15. Decedent's E (Specify only highest gr	ade completed)		6a. Deced Give I life I	lent's Usual Occu kind of work done OO NOT use retire	ipation e during most of worki ed)	6b. Kind of Busines	s/Industry				
the M	omp	Elementary/Secondary (0-12)	College (1-4or	5+)		cutive S	ent						
othe vent,	Be C	17. Father's Name (First, Middle, Las	t)	,									
arked atlc e	To	o Filchael Shea											
n 27 Is ⊞ ier traum		19a. Informant's Name/Relationship Robert Nalley (N		MD 20646	5								
if iten		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State											
rtant: njury		4 Donation 5 Other (Specify) Cedar Hill Cemetery Aug 12, 2009 Suitland, MD 21. Signature of Funeral Service Linears Control Linear Control Co											
any l		21. Signature of Funeral Service Line		1000			a Ferry Ro			20735			
-		23a. Part 1. Enter the disease, or cor	nplications that cause	2357 ed the death. D						Approximate Interval Between			
sician edical miner		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	. A481	s a consequence	e of):	TC C	AND) OU	4SCULA	几的分				
- 1		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Due to (or a	s a consequenc	e of):								
nd ransit	Examiner	that initiated events	c										
ng physician and as the burial-transit													
ohysic the bi	Medical	•	d										
After this certificate has been signed by the attending I funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♣No 9 □ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown		delivery Day Year								
ned by	by Ph	Part il. Other significant conditions	contributing to death	but not resulting	g in the ur	iderlying cause g	iven in Part I.	23e. Did toba	cco use contribute	to the cause of death?			
en sig uld be								1 ☐ Yes	2 ★ No 3□	Probably 4 Unknown			
ite has ber age 2 sho	Completed							24a. Was an autopsy performe 1 □ Yes 2	prior t	autopsy findings available o completion of cause of?			
ertifica ctor, p	Be C	25. Was case referred to medical examiner?						h (Check only one)					
this co al dire	ပ	1 Yes 2 No		tient 2 ER/		1 3 DOA		me 5 Residen		pecify)			
After	ion:	27. Manner of Death 1 → Natural 5 ☐ Pending	28a. Date of In (Month, E	Day, Year)	o. Time of Injury	28c. Inji Wo M 1 [ury at ork? □Yes 2□No	28d. Describe how	injury occurred				
Director: in by the	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not lead to determine determined.	he -	njury - At home, etc. (Specify)	farm, stre	eet, factory, office		28f. Location (Stre City or Town,		Rural Route Number,			
To the Funeral Director: completely filled in by the	Medical Ce			of examination			time, date and place, opinion, death occur						
сощр	Me	29b. Signature and title of certifier				29c. Licer	nse number	29	d. Date signed (Mo	nth, Day, Year)			
		1/10					182 47	A	06UST	7, 2009			
1		30. Name and address of person who					#207, W	aldorf, N	Maryland	20602			
Sta	ite	Philip Wisotsky, 31. Date filed (Month, Day, Year)	32. Regis	rtrar's Signature		Center	11/20/9 W	aruoii, r	ar y rand	20002			
Registı	ar	AUG 10	12009 🔀	never,	A. x	parker							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	1- State of Maryland / Departn Registrar State of Maryland / Departn Certifi	nent of Health and N cate of Death		ene 2 () () 9	27019
	Physicia		1. Decedent's Name (First, Middle, Last) Marion Thompson Cook		2. Date of Death Month Aug 7,	Day Year	3. Time of Death 3:38 A M
200	/Medic Examin			City, Town, or Location of Death		4c. County of Death	
	Funeral		5. Social Security Number	Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,	Year) 9. Birth	nplace (State or Foreign
	Director		470 20 4797 1 M 2 T F 86 Yrs. MO	Titalo Baye Titalo Titalo	Dec 14,	1922 Viro	oqua, WI
	aryland show	٦	10a. State 10b. County 10c. City, Town or Location P.G. Clinto				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	r 28a-f	irecto		0f. Zip Code	10	og. Citizen of What Cou	untry?
	ath with s 23a o	Funeral Director	14101 Livingston Road	20735	pecify Ves or No-	United Sta	
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the "Modical Examble" or the real penaltified at		1 Never Married 2 Married 1 Yes 2 No	Decedent of Hispanic Origin? (Sps, specify Cuban, Mexican, Puerto		Black, White	nite
21215-0036	iithin 72 ho ne. han "natu Mation!	Completed by	(Specify only highest grade completed) (Give kind life. DO N	s Usual Occupation of work done during most of work NOT use retired) emaker	king	16b. Kind of Business/f	
	filed within I Hygiene. other than ' ent, the Ma	Be Co	12 Z HOME 17. Father's Name (First, Middle, Last)		ne (First, Middle, M		
Maryland	12 should be filed within 7 th and Mental Hygiene. 7 is marked other than " traumatic event,	To B	Frederick H. Thompson		ivian Jo		T. O. I.
	1 and 2 sh Health and em 27 is m ther traum			ddress (Street and Number or Ru 101 Livingston			20735
Baltimore,	permit. Pages 1 ar Department of Hea Important: If item i any Injury or other once.		20a. Method of Disposition 1			20c. Location - City or	
altim	permit. Page Department of Important: If any Injury or once.			Cemetery Aug 10 ame and Address of Facility Lee			
ä	permi Depar Impor any Ir		XALLY MASON Ale	exandria Ferry R	Road, Cli	nton, MD	20735 Approximate
10	Physician	i In	23a. Part 1. Enfer the "isease or complications that caused the death. Do not enter the shock, or hear ciliure. List only one cause on each line. Immediate ause to madify the state of conditions. Colon Cancer	e mode of dying, such as cardiac	or respiratory arre	est,	Interval Between Onset and Death 4 years
	/Medical Examiner		disease or condition resulting in death a. Due to (or as a consequence of):				
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Lause Libisease or injury				
ó	icate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):				<u> </u>
68760,	cate be physicia the bu	edical	d				
O. Box	eath certif attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 3□No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ec 4 □ Pregnant at time of death 5 □ Ot	otopic pregnancy her (specify)		23d. Date of del Month	livery Day Year
rds, P.	w requires that the d been signed by the should be detached	þ	Take in Other Significant Contained to Country to Country in the C	lying cause given in Part I.	23e. Did tob 1 ☐ Ye	bacco use contribute to es 2 ∏ No 3□ Pi	o the cause of death?
I Reco	The law re ate has bee page 2 sho	Completed			24a. Was ar autops perforr 1 ∐Yes 2	n 24b. Were at prior to death?	utopsy findings available completion of cause of
Vita	Physician: The raths certificate ral director, pag	Be	25. Was case referred to medical examiner?	0.11	ath (Check only on	ence 6 ☐Other (Spe	noify)
n of	ding Phys I. After this funeral di	on: To	27. Manner of Death 1 A Natural 5 Pending (Month, Day, Year) 1 I Natural 5 Pending	28c. Injury at Work?		ow injury occurred	
Division of Vital Records,	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate hy completely filled in by the funeral director, page	Certification: To	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No factory, office	28f. Location (St City or Town	treet and Number or R n, State)	ural Route Number,
-	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Co	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death or Check only one) Certifying Physician: To the best of my knowledge, death or Check only one)	curred at the time, date and place tigation, in my opinion, death occi	Le, and due to the durred at the time, d	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier Was A Kala Mary Re	29c. License number D20352	2	Aug 10	
	63		30. Name and address of person who completed cause of death (Item 23a) (Type, Prin Harry Katzen, M.D. 8926 Woodyard Road,	Suite 101, Cli	nton, MD	20735	
	Sta		CO Desistante Cimpatrus				
	Regist	rar	AUG 10 2009 Server B.	war -			

amended item 18/wchd/8-14-09/map

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State of Ma	-	epartmei Certifica			nd Me	ental Hy	ygiene Reg. No.	:009	27020
			1. Decedent's Name (First, Middle, La	st)					, 2	2. Date of D Month	eath Day	Year	3. Time of Death
	Physicia /Medic	_	Delworth Care	У						7	28	2009	11:02 ^M
	Examin	-	4a. Facility Name (If not institution, give	street and number)		,	, Town, or Lo		Death			County of Deal	
			4221 Market S		// (A) *		OW Hi	11 f Under 2	A Hrs o	Data of D		rceste	
	Funeral		5. Social Security Number 6. S	ex MM 2□F 96	e (In yrs. last birthe Yr	Months		Hours	Min.	B. Date of B (Month, D - 11-	ay, Year)	Co	thplace (State or Foreign ountry)
ш	Director		220-03-1373 Usuel Residence of Decedent		*					-11-	1713	V	4
	yland		10a. State 10b. County		10c. City, Town of	or Location							10d. Inside City Limits
	Mar-fet	tor	MD Worcest	er	Snow H	ill							1 □X es 2 □ No
	or 28	Director	10e. Street and Number			10f. Z	p Code				10g. Citiz	en of What Co	ountry?
	deeth with the Maryland ma 23a or 28a-f ehow rmust be notified at		4221 Market St	reet			1863				U.S.7		
	er de itami	Funerai	11. Marital Status	12. Was Decedent Armed Forces?		13. Was Deci If Yes, sp	edent of Hisp ecify Cuban,	anic Origi Mexican,	in? (Speci Puerto Ri	ffy Yes or N ican, etc.)	10-	 Race - Ame Black, Whit 	
30	hours after tural', or ita al Exemina	by F	1 Never Married 2 Marned 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ XI If Yes, Give Year or Dates:	10	1 🗆 Yes	2 No .	Specify:				Specify:Bla	ack
215-0036	d within 72 hours after deeth with the Marylar jiene, than, "natural," or itama 23a or 28a-1 ehow than "natural" or itama 23a or 28a-1 ehow the Medical Examinar must be notified at		15. Decedent's Ed		16a. D	ecedent's Us	ual Occupation	on				nd of Business	
2	within 72 ene. than "na he Medic	pie	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5	·/	Give kind of wife. DO NOT	use retired)	ing most (or working	,			
7	filed wil Hygien other th	Completed	11th		Me	chani					Aut		
yland	tal Hydra oth	Be	17. Father's Name (First, Middle, Last)							First, Middl			
	d Mer narka natic	2	Joseph Carey	Euro Deinel	105.1	Anillina Addan			Pol			otha Ju	
Ma	s 1 and 2 should f Health and Mer item 27 is marka other traumatic		19a. Informant's Name/Relationship (Marvin Purnell			24 Ma							
	1 and Health tem 27 other to		20a. Method of Disposition	/ Nepilew	20b. Place of Cometery,			50,	Dai		-	cation - City or	
Ē	80 = 5		1 Burial 2 Cremation 3 4 Denation 5 Other (Specif		Ebenez			્રે 8-	-2-2	009	Snow	Hill	. MD
Baltimore,	mit. Pa bartmen sortant: / injury :8.		21 Ignature of Fineral Service Licer	4	z z z z z z z z z z z z z z z z z z z	22. Name a	and Address	of Facility			Isab		
ñ	permit. Depart Import any inj once.		Questle	Jork		Benni Funer	e Smi	.tn		isbu		MD 218	301
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lii	the death. Do no	t enter the mo	de of dying,	such as c	cardiac or	respiratory			Approximate Interval Between
5	Physician		Immediate Cause (Final disease or condition	. (0	Roman	~ A	5 les	5	213	26	0		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):/							
	LAdminer	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of								
	ted nsit	nine	Cause (Disease or injury	D00 10 (01 as	a consequence of	1-							
,	be executed icien and burial-transit	Examin	that initiated events resulting in death) Last	C. Due to (or as	a consequence of):							
9	ate be executed hysicien and the burial-transit	cai	(d									
ğ	ntifica ng ph as th	Jedi	IF FEMALE:										
X R R	death certifica a attending ph id for use as th	an/h	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	of pregnancy 2 Petal death	3 ☐Ectopic	pregnancy				2	3d. Date of de	livery Day Year
o.	it the death certifica by tha attending ph tached for use as th	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at 9☐Unknown	time of death	5 Other (s	specify)					MOUTH	Day Teal
7.	The law requires that the site has been signed by thoage 2 should be detached.		Part II. Other significant conditions of	contributing to death h	ut not resulting in t	he underwing	CALISA DIVAD	in Part I		23e. Dio	tobacco u	se contribute t	o the cause of death?
ďs,	w requires that been signed b should be deta	d by	Hyperten	SIM	•	,,	J			1]Yes 2[robably 4 Unknown
င္ပ	v requestrent should	ete		0 -						24a. Wa	is an	24h Were a	utopsy findings available
Ď.	he lav e has age 2	Completed	- the beautiful	aemia						aut per	opsy formed?	prior to death?	completion of cause of
Vital Record		a	25. Was case referred to medical				2	6. Place	of Death /	1 ☐ Yes (Check only		1 🗆 Yes	s 2 No
	Physician: r this cartific ral director,	To B	examiner? 1 ☐ Yes 2 No	Hospital:	ont 2 ER/Outp	atient 3 🗆 🗈	Other			. /		G □Other (Spe	ecify)
n 01	ding Ph h. After th funeral		27. Manner of Jeath 1 Matural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. Tir y Year) Inj	ne of	28c. Injury a Work?	t	28	d. Describe	e how injur	y occurred	
S S	Attending or death. actor: Atterby the fune	catic	Accident investigation			М		s 2 🗆 N					
Division	or Atteniation of the deat	Certification:	3 Suicide 6 Could not b 4 Homicide determined		ury - At home, farn c. <i>(Specify)</i>	n, street, facto	ry, office		28		(Street and own, State		ural Route Number,
_	Hospitel or At 24 hours after o Funeral Direct etely filled in by		29a, Certifier 1 Certifying Pi	nysician: To the best	of my knowledge	death coours	d at the time	date and	t place, an	nd due to th	e cause(s)	and manner a	s stated
	24 hc 24 hc Fun etely	Medicai	(Check only 2 Medical Examone)	niner: On the basis of and manner sta	examination and/	or investigation	n, in my opin	ion, death	h occurred	at the time	e, date and	place, and du	e to the cause(s)
	To the Hospitei or A within 24 hours after To the Funeral Dirac completely filled in by	Me	29b. Signature and title of certifier	1		2	ec. License n					e signed (Mon	
	(00 1)		> VM	/			D3	471	68			8-5-0	39
	hoch		30. Name and address of person who	completed cause of d	eath (Item 23a) (T	ype, Print)	<u> </u>	A*1					
	V		Letterey Wiel	And, mi	, Po Bo	(49,	SALIS	bur	Ly,	MID	268	03	
	Sta Registr		31. Date filed (Month, Day, Year)	2009 32. Registr	eath (Item 23a) (T Po Boy ar's Signature	fork			U				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] amend item 1 For state #29a, per schd, 08/11/09 tj Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** L. CROCKETT 0925 PRESTON 2009 /Medical County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. Examiner 9. Birthplace (State or Foreign Country) Virginia Security Number 6. Sex 8. Date of Birth **Funeral** Days Min 1 ☑ M 2 ☐ F 227-76-4753 63 June 16, 1946 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, The Medical Evernhet must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Crisfield 1 ☐ Yes 2 X No Director Maryland Somerset 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21817 4232 Hill Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Tyes 2 No If Yes, Give Year or Dates: Vietnam 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machinist Sherwin-Williams Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Amanda Jane Parks Charles Crockett ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4232 Hill Lane - Crisfield, MDShirley Crockett (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 8/8/09 Salisbury, MD 21. Signature of P n ... Se in the second Robert H. Bradshaw 22. Name and Address of Facility Bradshaw & Sons 306 W. Main St. 21817 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Myclo blass mith. /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of burial-trar Due to (or as a consequence of): physician Physician/Medical the as attending properties of the second yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 5 ☐ Other (specify) ☐Yes 2☐No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Monpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c, Injury at Work? Injury 1 🛛 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Box 68760 P.O.

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, ours after death.

eral Director: After this certific filled in by the funeral director,

within 24 hours a

To the Funeral C completely To the

State Registrar

6 ☐ Could not be

determined

29c. License number

Excertifying Physiciam. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

nurse practitioner and manner stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAlisbury Md. 21801 WildMAN CRNP

31. Date filed (Month, Day,

29b. Signature and title of certifier

3 ☐ Suicide

29a, Certifier

4 ☐ Homicide

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

		-	State of Maryland / E State Registrar		rtment of H tificate of L			jiene Jeg. No.	009	27022
			1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	Day	Year	3. Time of Death
	Physicia /Medic		CHARLES EUGENE DONALDSON IV				AUGUST	_	009	5:00A M
	Examin	er	4a. Facility Name (If not institution, give street and number)			Location of Death			ounty of Death	
and the same			316 OVERTURE WAY 5. Social Security Number 6. Sex 7. Age (In yrs. last bir.	thday)	CENTREVI	LLE If Under 24 Hrs.	8. Date of Birth		EEN ANI	nplace (State or Foreign
	Funeral Director		-5	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day 6 / 27 / 19	, <i>Year)</i> 948	Col	RI
-		t	Usual Residence of Decedent							
	ryian show	_	10a. State 10b. County 10c. City, Town							10d. Inside City Limits 1 X Yes 2 □ No
	8a-f s	Director	MD QUEEN ANNE'S CENTRE	V ТГ.				40- Oitima	n of What Co	
	or 2		10e. Street and Number		10f. Zip Code				II OI WIIAI COI	uniti y r
	sath v	eral	316 OVERTURE WAY 11 Marginal Status 12. Was Decedent Ever in U.S.	13 \	21617	ispanic Origin? (Sp	ecify Yes or No-	USA 14	. Race - Ame	rican Indian,
	item incl	Funeral	Armed Forces?	10.	Vas Decedent of Hi f Yes, specify Cuba		Rican, etc.)		Black, White	, etc.
<u>ن</u>	tiled within 72 hours after death with the Maryland Hygiene, ther than "natural", or items 23a or 28a-f show ent, its Madical Evaniment or nutitied at	ð	1 ☐ Never Married 2 ☐ Married 1 ☐ Mes 2 ☐ No If Yes, Give 1966—1969 Year or Dates:)	I∐Yes 2 X No	Specify:		Si	pecify: W	HITE
ှ ည	thin 72 ho e. an "natur Medical	eted	15. Decedent's Education (Specify only highest grade completed)	Deced (Give	dent's Usual Occupa kind of work done of OO NOT use retired	ation during most of work	ing	16b. Kind	of Business/I	ndustry
[2]	han "	Completed	Flementary/Secondary (0-12) College (1-4or 5+)		OO NOT use retired ANCIAL DI			AII	TOMOTI	VE
2	il Hygie other t rent, in	e Co	17. Father's Name (First, Middle, Last)	PIN	ANGIAL DI	18. Mother's Nam	e (First, Middle,			<u>, </u>
Maryland 21215-0036	S 22 20	8	CHARLES EUGENE DONALDSON III			PATRIC	IA QUIN	N		
3	is 1 and 2 should by Health and Ment Item 27 is marked other traumatic e	٩		. Mailir	ng Address (Street	and Number or Ru	ral Route Numbe	er, City or T	Town, State, 2	Zip Code)
	and 2 ealth a n 27 is		DONNA DONALDSON/WIFE 3	16	OVERTURE	WAY, CEN	TREVILL			
	iges 1 a nt of He : If Item or oth		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 20b. Place o CHESAT	f Dispo	sition (Name of	ton Augus	Date ST 11	20c. Loca	ation - City or	Town, State
Ĕ,	ment ment lant: I		4 □ Donation 5 □ Other (Specify)	CEN	TER	200	9	STEV	ENSVIL	LE, MD
Baltimore,	permit. Pages 1 Department of H Important: If Ite any Injury or ot once.		21. Signature of Euneral Service Licensee	FE	Name and Addres LLOWS, HI 8 S. LIBI	ELFENBEIN	& NEWN	AM FU	NERAL MD 21	HOME 617
			23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
P	hysician		Immediate Cause (Final disease or condition MYS CARD 4	H	INFAY	RCTION				10 hours
1	/Medical Examiner		resulting in death) Due to (or as a consequence	of):	- 3-	,				15
	_xammer	<u></u>			ELLIT	LS				11) years
	uted d insit	Examine	cause. Enter Underlying Cause (Disease or injury	,-						
o,	an and rial-tra		that initiated events resulting in death) Last	of):						
8760	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical	d							
9	ertific ling p	Med	IF FEMALE:							
Вох	eath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death		☐ Ectopic pregnanc☐ Other (specify) _	у		23	3d. Date of de Month	Day Year
P. O.	the d	ysic	1 Yes 2 No 9 Unknown							
O .	uires that the de signed by the a d be detached f	by Pr	Part II. Other significant conditions contributing to death but not resulting it	n the u	nderlying cause giv	en in Part I.	23e. Did t	obacco us	e contribute to	the cause of death?
ğ	w requires been sig should b	ed b					1 🗆 '	Yes 2	No 3□P	robably 4 🗌 Unknown
Division of Vital Records,	e law re has be e 2 sho	Completed					24a. Was	osv	24b. Were a	utopsy findings available completion of cause of
<u> </u>	The ate h	Com					perfo 1 □ Yes	rmed? 2 No	death? 1 ☐ Yes	2 X No
Ħ.	sician: The certificate h rector, page	Be (25. Was case referred to medical examiner?		104	26. Place of Dea				
o	Physic this craft dire		1 ☐ Yes 2 1 No Hospital: 1 ☐ Inpatient 2 ☐ ER/O 27. Manner of Death 28a. Date of Injury 28b.	utpatie Time c	III 3 LI DOA		ome 5 Resi			ecify)
uo	ding h. After funer	tion	1 Natural 5 ☐ Pending (Month, Day, Year)	Injury	Wor	k? Yes 2 □ No	200. D0001100	now wijery	00001100	
is i	or Attending P after death. I Director: After I d in by the funers	fica	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, for	arm, st					Number or A	ural Route Number,
á	al or	Certification: To	4 ☐ Homicide determined building, etc. (Specify)				City or To	wii, Siale)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director; to make the funeral dir	edical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge and manner stated.	je, dea nd/or ii	th occurred at the tinvestigation, in my	ime, date and place opinion, death occu	e, and due to the irred at the time,	cause(s) date and	and manner a place, and du	is stated. e to the cause(s)
	o the	Med	29b. Signature and title of certifier		29c. Licens			29d. Date	signed (Mon	th, Day, Year)
	->-°		> Au A Noble mo		(00415	87	3	3/10	109
			30. Name and address of person who completed cause of death (Item 23a)					011	00	
			HELEN A. NOBLE M.D. 122 SPEER RO	AD,	SUITE 5,	CHESTER'	rown, MI	216	20	
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature	1	barre					

dent's Name (First, Middle, ity Name (If not Institution, 0.15 Bayer Dro Security Number 0-24-3650 esidence of Decedent te 10b. County	Loi give street end nu		beth E	nglis	:h			2. Date of De Month	Day	Year	3. Time of Death
D15 Bayer Dra Security Number 2-24-3650 esidence of Decedent	give street end nut ive Apt.# 3. Sex	mber)	beth E	nglis	h						I a a a M
D15 Bayer Dra Security Number 2-24-3650 esidence of Decedent	ive Apt.#							August	: 18,	2009	12:43 A M
Security Number (-24-3650) esidence of Decedent	6. Sex	В		4b. City,	Town, or	r Location	of Death		4c. Ce	ounty of Death	
-24-3650 esidence of Decedent					Smit	thsbu	rg			Washir	ngton
esidence of Decedent	1 L M 2 K F	7. Age (In yrs. I	last birthday)	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Bi (Month, D	rth	9. Birth	place (State or Foreig ntry)
		81	Yrs.	WOITH	Days	Hours	IVIII.	May 14	, 1928		aryland
te 10b. County		1									
		10c. City	y, Town or Lo	cation							10d. Inside City Limits
	ngton				Smi	thsb	urg				1 □ Yes 2 🙀 No
eet and Number				10f. Zip	Code				10g. Citize	n of What Cou	ntry?
2015 Bayer D	rive Apt	.#B			217	783			1	U.S.A.	
tal Status	12. Was Dece	edent Ever in U.	S. 13. V	Vas Deced	ent of H	ispanic O	rigin? (Sp	ecify Yes or N	D- 14		
Never Married 2 Marrie	d 1 Tes	21 No						7 110011, 010.7			
Widowed 4 ☐ Divorced	Year or D	ates:		10103 2	LAINO	Opecny			Sį	pecity: W	hite
15. Decedent's	Education grade completed)		16a. Deced	dent's Usua	l Occup	ation	et of work	ring	16b. Kind	of Business/In	dustry
		-4or 5+)	life. L	OO NOT us	e retired	f)g), UI WUIN	g			
10				Home	make	r				Home	
	·					18. Moth	er's Nam	e (First, Middle	, Maiden Su	ırname)	
Leslie Itny	re					_	Mau	de Matt	hews		
ormant's Name/Relationshi	p (Type. Print)		19b. Mailin	g Address	(Street	and Numb	er or Rui	rai Route Numb	er, City or T	own, State, Zij	Code)
ry I. Englis	h (Husi	band)	12015	Baye.	r Dr	. Ap	t.#B	Smiths	burg,	Maryla	nd 21783
•		20b. P						Date			
		State				i i			Smi+1	shura.	Maruland
Jalley /	Dalie	MO:	1414				Ĺ				
rt 1. Enter the disease, or c	omplications that c	aused the death				-				, margr	Approximate
	nly one cause on e	ach line.	1		_			,			Interval Between Onset and Death
or condition	a		0/00		one	0					9 month
	Due to (or as a consequ	uence of):								
tially list conditions,	b. Due to	'or oo o oonooo	ionos of								
Enter Underlying	Due to (or as a consequ	derice oi).								
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	Due to (or as a consequ	ience or).								
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s decedent pregnant	1 Live b	oirth 2 🗆 Fetal	death 3	Ectopic pr	egnancy	У			230		,
Yes 2 □ No			eath 5□	Other (spe	ecify) _					WOULL	Day Year
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ther significant condition	s contributing to de	eath but not resu	Ilting in the un	iderlying ca	use give	en in Part i	I.				
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									an :	24b. Were auto	ppsy findings available
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case referred to medical						00 Di	4 D4			1 ∐Yes	2 LI No
niner?	Hospital:		FD/0-4		Othe						
	1 1 1		·		Α	4 LI N	ursing Ho				fy)
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Suicide 6 ☐ Could no	t be 290 Place	of Injune At I -	mo form ot-			res ∠∐		006 1 0			10 11 1
doto resin	ad Zoe. Place	ng, etc. (Specify	nie, iarm, stre	et, ractory,	ОПІСВ			City or To	Street and I wn, State)	vumber or Run	ai Houte Number,
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eck only 2 Medical E:	kaminer: On the ba	asis of examinat	wiedge, death tion and/or inv	occurred a restigation,	at the tin in my o	ne, date a pinion, de	nd place, ath occur	and due to the red at the time	cause(s) ar date and pl	nd manner as : lace, and due t	stated. o the cause(s)
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nature and title of certifier	1	/ 4		29c.	License	e number				1.0	
Muchael	1h	whon	MO	1	14	166	7		8	. 18.	09
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State Registrar 31. Date filed_(Month, Day, Year)

32. Registrar's Signature

09-06282 Constantine Frank

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 27024

		1- For State Certificate of Death Reg. No.												2 102			
Physicia	an/	Decedent's Name (First, Middle,Last)										Date of Death Month Date				3	3. Time of Death
edical Exami	ner	Constan	ntine		Fran!	K		4b. City, Town, or Location of Death					Month August 1	1, 2009	Year		1338 hrs
)		4a. Facility Name (i Johns Hopk			street and n	umber)		4	b. City, To Baltim	Death			County of N/A	Death			
Funeral		5. Social Security N	In yrs. last bi	rthday)	If Under		If Under		8. Date of B	irth(MM/DI	D/YYYY)	9. Birth	place (State or Maryland				
Director		212-52-07		1 <u>X</u>	M 2 F	Telescope Services Months Days Hours Min. 04/08/1955								Cour			
my		Usual Residence of 10a. State	10b. County			10	Oc. City, Tow	n or Locati	on							1	Od. Inside City Limits
r death with the Maryland or items 23a or 28a-f show any must be notified # once.	_	MD	Balt	imor	e			Bald	win								1Yes 2 ▼ No
larylar 8a-f	Director	10e. Street and Nur	mber	-					10f. Zip (Code				10g. Citize	n of Wha	t Countr	ry?
the M a or 2 tified		12 Tur	mer Wo	bod	Court			21013					USA				
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. nnt: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified of once	Funeral	11. Marital Status			12. Was De Armed F		ver in U.S.	13. Wa	s Deceden es, specify	t of Hispa	anic Origi Mexican	n? (Spec	cify Yes or N	0- 14	4. Race - White,		an Indian, Black,
r deat or ite must	Fun	1 Never Marrie			1 Yes	2 X	No						our, oto.,				+
rs afte	by	3 Widowed 15. Decedent's Ed			If Yes, Give Ye or Dates:		oted) 16a	. Deceden	Yes 2			ind of wo	rk done		pecify: nd of Busi	Whi	
2 hou "nat	eted	Elementary/Seco				1-4 or 5+)			ost of work								
21215-0036 and be filed within 7 Mental Hygiene. marked other than c event, the Medica	Completed	1			2				Vend	or					Ven	ding	3
5-0 led wi Hygie other		17. Father's Name				,				18			irst, Middle,				
121 d be fi ental arked	Be		Nichola			1K							ine J				
D 2 Should and M 7 is m	2	19a. Informant's Na Jacqui F					1		Address Turn				ral Route Nu ∔ 1	imber, City Baldw			21013
Baltimore, MD 21215-0036 pemir. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		20a. Method of Disp		DL	Ouse		20b. Place						Date		<u> </u>		own, State
nore nores 1 nores 1 t: If i		1 Burial 2					1	atory or oth				0/17	/2000	7.7-	_ 27		140
Itin nit. Pa artmen ortan ry or		4 Donation 5 21. Signature of Fu				ment	Green	22. N	ame and A	ddress o	of Facility	0/ I / Bea	/2009 11 Fu	neral	odla Hom	wn,	
Ba Depu		Thomas 1			per	DVR			512 N					wie,		2071	5
Physician		23a. Part I. Enter th	le disease, or	compli	cations that	caused the	e death. Do i									t	Approximate Interval Between Onset and
/Medical ∼ ⊊xaminer		Immediate Cause (Final disease		Intrac	cereb	ral he	emorr	hage	asso	ciat	ed w	ith a	n ass	au1t		Death
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lecords, P.O. Box 68760, The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial - transit	/Medical	X UNPENDED		X	AMENDED		per f 27,28		4,08 per 1	/25/g	39dh]	0/20	/09 т				
8760, ificate be up physic s the burn		IF FEMALE: 23b. Was decedent		he	23c. If yes,		of pregnanc		tal death	3	Ectopic	pregnan	cv		Date of o		ay Year
of Vital Records, P.O. Box 68 the Physician: The law requires that the death certificate After this certificate has been signed by the attending funeral director, page 2 should be detached for use as	Physicia	past 12 months					me of death		ner (Speci								
Bo he dea the d	hys	1 Yes 2 N		known	9 Unkr								Did Did	tobases un	an contrib	uto to th	ne cause of death?
P.O.	by F	Part II. Other signi	ncant cono	uons	contributing	to death b	out not resulti	ng in the u	naenying i	cause giv	ven in Par	τι.			_	_	ably 4 Unknown
ds, duires	ted												24a. Wa				opsy findings available
COT law re has be	Completed	-								.				opsy formed?		ior to co eath?	empletion of cause of
		OF Monages refer	and to madio						2	· Diasa	of Death (Chook or		2 No	1	✓ Yes	2 No
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Di spital nours a	Certification:	4 X Homicide	dete	rmined	(Specify) WOL	. K.					Į.	Baltim	ore,	MD		
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director,		29a. Certifier (Check only one)	Certifying P Medical Exa	hysicia	in: To the be	est of my k	knowledge, d	eath occur	red at the t	ime, date	e and place	ce, and d	ue to the ca	use(s) and te and plac	manner	as state	d. cause(s)
To t With To t	Medical	29b. Signature and			and manner	stated.				License							th, Day,Year)
	-		10	7	1/ 11					O.C.N				- 1	ıst 12,	•	,,, ,
		30. Name and add	ess of pare	Who	mpleted car	I'M	ath (Item 23a))								_	
TAB		Pamela E. S	The same of the sa				al Examin		1 Penn	Street,	Baltim	ore, MI	21201				
	tate	31. Date filed (Mont	th, Day,Year)	9 21	009 32. F	Registrar's	Signature	,					_				
Regis			TUU A	v <u>41</u>	100	Reeve	a p	1	Wad								
DHMH 17 Rev 1/2	100						O	RIGINA	L								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

		•	FOR ITELEVILLE	Certificate of Death		. No. 2015	27025	
	Physicia	an	Decedent's Name (First, Middle, Last) MARY FREDERICK		2. Date of Death Month AUGUST 1	Day Year	3. Time of Death 10:30 A.M	
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death		
an port	Funeral		4807 RAEMORE LANE 5. Social Security Myrs, last birth 6. Sex 7. Age (In yrs, last birth	BOWIE hday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,	PRINCE GE(DRGE 'S place (State or Foreign ntry)	
	Director		219-12-9772 1 M 2X F 84 Y	Yrs. Months Days Hours Min.	NOV. 7,	1924 MAR	YLAND	
	yland		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location			10d. Inside City Limits	
	he Mar 28a-f s	Director	MARYLAND ANNE ARUNDEL BROOKLY	YN 10f. Zip Code	100	g. Citizen of What Cou	1X Yes 2 No	
	3a or 2	ig E	10e. Street and Number 632 DOUGLAS STREET	21225	100	U.S.A.	,	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Medical Exertifical must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto			etc. HITE	
Maryland 21215-0036	within 72 ho iene. than "natui re Medicel	Completed by	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ring	6b. Kind of Business/Ir	,	
121	iled wit Hygien ther th	Co	12 PA	AYROLL CLERK 18. Mother's Nam	PF e (First, Middle, Ma	RIVATE SECT aiden Surname)	TOR	
lan	ald be f Aental I rked of tic eve	To Be	THOMAS H. COBURN	PEARL A.	STRICKER	}		
Aary	2 shou and N Is mai			Mailing Address (Street and Number or Ru				
	s 1 and 2 f Health tem 27 I other tra		20a. Method of Disposition 20b. Place of	2 DOUGLAS STREET, BA Disposition (Name of y, crematory or other place)		MARYLAND Oc. Location - City or T	21225 Town, State	
Baltimore,	Pages ment or ant: If I ury or		I TA Burial 21 I Cremation 31 I Removal from State 1	ND VETERANS 8/6			, MARYLAND	
Balt	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility RO 16000 ANNAPOLIS ROA			RAL HOME, 20715	
			23a. Part1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) END STAGE BREAS Due to (or as a consequence of the content o				YR	
	Examiner		CHRONIC OBSTRUC	CTIVE PULMONARY DISE	ASE		YRS	
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	of): ITH HEART FAILURE		0	YRS	
68760,	rificate be executed og physician and as the burial-transit	ledical Exa	resulting in death) Last Due to (or as a consequence of CORONARY ARTER)	•			YRS	
O. Box	death cer e attendin d for use	Completed by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deli Month	ivery Day Year	
rds, P.	w requires that s been signed b should be deta	d by Pi	Part II. Other significant conditions contributing to death but not resulting in DIVERTICULOSIS, GLAUCOMA, ANEMIA, I			the cause of death? obably 4 \(\subseteq \text{Unknown} \)		
Division of Vital Records,	The la ate has				autopsy perform 1 □ Yes 2	24a. Was an autopsy performed? 1 □ Yes 2 ▼No 1 □ Yes 2 ▼No 1 □ Yes 2 ▼No 2 ▼No 1 □ Yes 2 ▼No		
V:It	Physician: r this certific ral director, I	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou	Othor	th (Check only one ome 5 Resider		cify) DAUGHTER '	
n of	ing Phy Viter thi uneral o	on: T	27. Manner of Death 1 X Natural 5 ☐ Pending 28a. Date of Injury (Month, Day, Year) Ir	Time of njury at Work?	28d. Describe how		HOME	
Divisio	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification: To	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	M 1 □Yes 2 □No rm, street, factory, office	28f. Location (Str. City or Town,	eet and Number or Ru State)	ıral Route Number,	
	e Hospital or 24 hours afte e Funeral Dir letely filled in	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination an and manger stated.	e, death occurred at the time, date and place ad/or investigation, in my opinion, death occu	e, and due to the ca urred at the time, da	use(s) and manner as ite and place, and due	s stated. to the cause(s)	
	To the within 2 To the complete	Me	29b. Signature and title of differ Reilly	MD 29c. License number D54749		AUGUST 4,		
(48.		30. Name and address of person who completed cause of death (the 23a) (ALLEN REILLY, MD, 12304 BALTIMORE I	(Type, Print) BLVD., BELTSVILLE, M	ARYLAND			
	Sta Registi		31. Date filed (Month, Day, Year) AUG 07 2009 AUG 0 7 2009	1. parl				

			State Registrar Amended 08	/10/2009 per	FH Ce	rtificate of	Death# 20b		. No. 2009	27026
	Dhysisis		1. Decedent's Name (First, Middle, Las	t)				Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Verna Thelma Grig	sby				August 2	2, 2009	4:30 P ^M
and the	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death		4c. County of Dea	th
-			Lorien of Mount A	iry		Mount Ai	ry		Carroll	
	Funeral		5. Social Security Number 6. So	ex 7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min.	B. Date of Birth (Month, Day, Y	(ear) 9. Bir	thplace (State or Foreign ountry)
	Director		578-07-0406	□M 2 X F 8	9 Yrs.	MOTITIS Days				hington, DC
	ъ		Usual Residence of Decedent							T
	ylan		10a. State 10b. County	10c. Cit	ty, Town or Lo	ocation				10d. Inside City Limits
	Mar a-fs	혅	Maryland Montgome	rv Dama	scus					1 □Yes 2X No
	r 28	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	ountry?
	3a o		1 Clearwater Cour	t		20872		US	SA	
	ms 2	Funeral	11. Marital Status	12. Was Decedent Ever in U.	.S. 13.	Was Decedent of H	lispanic Origin? (Spec	14. Race - American Indian,		
10	fter (Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐Yes 2 X No			an, Mexican, Puerto R	Black, White, etc.		
္က	al",o	by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 □Yes 2X No	Specify:		Specify: W	nite
ŏ	2 hou	Completed	15. Decedent's Ed	ucation		edent's Usual Occup		16b. Kind of Business/Industry		
5	in 72 in "in	ple	(Specify only highest gra		(Give	e kind of work done DO NOT use retire	during most of working d)	g		
7	with iene tha	E	Elementary/Secondary (0-12)	College (1-4or 5+)	Homema	aker		Oъ	n Home	
0	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ant, it a Marical Extrairer must be maithed at		17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, Ma	iden Surname)	
an	antal	Be c	Uilliam Warner Do	210			Annie M.	Poole		
\geq	should and Mer s marke umatic	욘	William Warner Po 19a. Informant's Name/Relationship (19h Maili	ing Address (Street	and Number or Rural		City or Town, State.	Zin Code)
Ma	A 10 60					_				20872
a)	l and a Health sm 27		Raymond Grigsby, 20a. Method of Disposition				Court, Dam		oc. Location - City or	
Ö	des it of it		1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State		osition (Name of matory or other pla	ce)			, Maryland , Maryland
Ξ.	Pa men ant:		4 ☐ Donation 5 ☐ Other (Specify) Pin	e Grov	e Cemeter	y 8/7/20	009 M	ount Airy	, Maryland
Baltimore, Maryland 21215-0036	permit. Pages 1 and Department of Heali Important: If Item 2 any injury or other once.		21. Signature of Funeral Service Licen	see						Funeral Home
<u></u>	20 = 20		Kirgy M.	1) Irger	20	6401 R i dg	e Road, Da	mascus,	Maryland	20872
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only		h. Do not en	iter the mode of dyi	ng, such as cardiac or	respiratory arres	st,	Approximate Interval Between
Tan,	Physician		Immediate Cause (Final disease or condition	a End Stage I	uno N	oorlasm				Onset and Death
	/Medical		resulting in death)	a. Due to (or as a conseq		COPIASM				
	Examiner		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	h Pneumonia						Wk
		ē	Sequentially list conditions, if any, leading to mineralate cause. Enter Underlying Cause (Disease or injury	Directo (or es a consuc	uence of):					
	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	_c Emphysema						Yrs
B	xecu and	Xal	that initiated events resulting in death) Last	Due to (or as a consec	uence of):			*		
9	be e			d Hypertensic	1 D					Yrs
68760,	ficate be executed g physician and s the burial-transit	Medical		d Hypercensic	J11					1110
	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit		IF FEMALE:	23c. If yes, outcome of pregn	ancv		Ø		Old Date of d	o listore t
Box	ath c	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Feta	al death 3	Ectopic pregnan	су		23d. Date of do	Day Year
o.	the a	sic	1 □Yes 2 □No 9 □ Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown	ueam 5	Other (specify) _				
P. 0.	w requires that the de been signed by the should be detached	Physician/	Part II. Other significant conditions of	antributing to death but not res	sulting in the I	underlying cause di	ven in Part I	23e. Did toba	cco use contribute	to the cause of death?
Ś	es the	þ	_				voir iii r care i.			Probably 4 🗆 Unknown
בַ	eduir sen s buld	Completed	Chronic Gastroen	teritis, com	LIS, A	пхтесу		i li tes	2 10 320	-Tobably 4 Officiowit
ပ္ထ	e law m has be	bet	Thoracic/Lumbosa	cral Neucritis	s, Rad	iculitis		24a. Was an autopsy	24b. Were a	autopsy findings available o completion of cause of
ď	The I	E						performe	ed? death?	s 2□No
tal	an: tiffica or, p		25. Was case referred to medical				26. Place of Death			.3 2
5	s cer irect) Be	 examiner? 1 ☐ Yes 2 X No 			ecify)Assisted				
οţ	Phy er this eral c	Ë	27. Manner of Death	1 ☐ Inpatient 2 ☐	28b. Time	of 28c. Inju		8d. Describe how		Living
on	ding P. Afte fune	ţi	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	Injury		rk?]Yes 2 □ No			
S	Attending Physician: or death. ector: After this certification by the funeral director, I	fica	3 ☐ Suicide 6 ☐ Could not b		lome, farm, s			8f. Location (Stre	eet and Number or I	Rural Route Number,
Division of Vital Records,	or A after Direc in by	Certification: To	4 ☐ Homicide determined	building, etc. (Speci	ify)	,,		City or Town,	State)	
	the Hospital of thin 24 hours a the Funeral Dimbletely filled in mpletely filled in		29a, Certifier 1X Certifying Pt	nysician: To the best of my kn	owledge des	ath occurred at the t	time, date and place a	and due to the ca	use(s) and manner	as stated.
	Hos 24 hc Fun Fun	ica	(Check only 2 Medical Examone)	niner: On the basis of examin	ation and/or	investigation, in my	opinion, death occurre	ed at the time, da	te and place, and di	ue to the cause(s)
	The Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29b. Signature and title of certifier	and manner stated.		29c. Licen	se number	29	d. Date signed (Moi	nth, Day, Year)
	.0 - 0 0	_		11 4114						

State Registrar

Allen Reilly, MD, 801 Tollhouse Avenue, D-1, Frederick, Maryland 21701 31. Date filed (Month, Day, Year) AUG 10

30. Name and address of person who completed cause of d ath Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

August 6, 2009

		1 - For State Registrar	State	of Marylar	•	artment of H rtificate of E			Reg. No.		27027		
Physic	ian			NT DO TO	,			2. Date of I Month AUGUS	Day	Year 2009	3. Time of Death		
						4b. City, Town, or	Location of Deat			ounty of Death			
Z	ilei	ANNE ARUNDEL	MEDICAL O	CENTER			APOLIS			ANNE AR			
		5. Social Security Number 030–38–4966	6. Sex 1 X M 2 □ F			If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month,	Birth Day, Year) 9, 194	Con	nplace (State or Foreign Intry) SSACHUSETTS		
land ow				10c. C	ity, Town or Lo	cation					10d. Inside City Limits		
Mary a-f sh	ţċ	MARYLAND OU	TEEN ANNE'	EN ANNE'S STEVENSVILLE						1 □Yes 2 X No			
Physician // Medical Examiner Funeral Director		10f. Zip Code			10g. Citizen of What Country?								
ath w s 23a nust b	ral		1 10 01 5		10 10		1666	D!6.V	1	red sta			
urs after de al", or item	þ	1 ☐ Never Married 2 🔀 Mar	ried Armed F 1 □Yes If Yes, G	forces? 2 X No Sive		Was Decedent of His If Yes, specify Cubar 1 □Yes 2 X No	Specify:	to Rican, etc.)		4. Race - Amer Black, White Specify: W			
72 ho	eted	15. Deceder (Specify only highe	nt's Education est grade completed)	16a. Dece (Give	dent's Usual Occupa kind of work done d DO NOT use retired)	ation uring most of wo	rking		of Business/I			
within sne.	du	Elementary/Secondary (0-12)			`life.	DO NOT use retired) SALES MAI				JSTRIAL LPMENT			
filed v Hygir other t		17. Father's Name (First, Middle,					18. Mother's Na	me (First, Mida					
Id be fental rked c	0	PETER FRANK GA	NDOLFO, S	SR.			DORA	E. BRO	OWN				
and N and N s man	-	19a. Informant's Name/Relations	ship (Type. Print)		19b. Maili	ng Address (Street a	nd Number or R	ural Route Nur	nber, City or	Town, State, Z	Tip Code)		
and 2 and 2 lealth m 27			LFO/WIFE		_	DAVOL ROAI	7						
t. Pages 1 rtment of H rtant: If ite		1 ☐ Burial 2 【X Cremation 4 ☐ Donation 5 ☐ Other (S	Specify)	State CH	ESAPEA	osition (Name of matory or other place KE_CREMAT] ENTER	LON 2	UST 14 2009		ation - City or T	E, MARYLAND		
Depariment of the policy of th		21. Signature of Funeral Service	Licensee	2000	F.	2. Name and Addres ELLOWS, HI	ELFENBEI	N AND N	IEWNAM	FUNERA	L HOME, P.A		
		23a. Part 1. Enter the disease, o	r complications that			06 SHAMROO				KYLAND	Approximate		
. Physician	ı	Immediate Cause (Final	only one cause on								Interval Between Onset and Death		
			a. Due to	(or as a consec	quence of):	araiay.	0,00	1000					
Examiner			, (oruner	2	Merosc	levosis				years		
p ±	iner	if any, leading to immediate cause. Enter Underlying	Due to	o (or as a consec	quence of):								
ecute and I-trans	xam	that initiated events resulting in death) Last	c	Or as a conse	quence of):								
be e				7 (01 40 4 0011001	4401100 01/1								
ificate g phys	edic		d										
he death cert the attending	ysician/M	23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No	1 ☐ Live 4 ☐ Pre	birth 2 Fet gnant at time of	al death 3	☐ Ectopic pregnancy ☐ Other (specify)			- 23	3d. Date of deli Month	ivery Day Year		
that the the the the the the the the the th			ons contributing to	death but not re:	sulting in the u	nderlying cause give	n in Part I.	23e. Di	d tobacco us	e contribute to	the cause of death?		
quires n sign	d b	Diabetes	Mell.	this				1[∐Yes 2□	No 3 ⊡- Pr	obably 4 ☐ Unknown		
aw rec	olete	Hyperter	rsion					24a. W		24b. Were au	topsy findings available		
The la	E O	Ductions	PVILLA					pe	topsy rformed?	death?	completion of cause of		
sian: ertifica ctor, p			-				26. Place of De	-					
hysic this co		1 Yes 2 No	1_				4 🗀 Nursing i	Home 5 ☐ Re			cify)		
ling F	ion:	1 Natural 5 ☐ Pendir	ng (Mo	e of Injury onth, Day, Year)	28b. Time of Injury	Work	rat ? ⁄es 2 ⊡No	28d. Describ	e how injury	occurred			
death ctor:	licat	3 Suicide 6 Could	not be	ce of Injury - At h	nome, farm, st		res 2 🗆 NO	28f. Location	(Street and	Number or Bu	ıral Boute Number.		
pital or A		4 Homicide building, etc. (Specify) City or Town,											
24 ho 24 ho Fun etely	dica	(Check only 2 Medical	Examiner: On the	basis of examin	ation and/or ir	nvestigation, in my op	pinion, death occ	curred at the tin	ne, date and	place, and due	to the cause(s)		
To the within To the	Me		7)			29c. License	number		29d. Date	signed (Monti	h, Day, Year)		
		Tu C	tand			D3-	7064		0	8/11/	09		
1042		30. Name and address of person	who completed car			1	art 1		1	1 - 1			
1,				·		S2/1/1 D-	Steve	ensulla	, Mi	246	66		
St Regist		31. Date filed (Month, Day, Year,	32.	Registrar's Sign	ature				-				
DHMH 17 Rev 1/	-	AUG 12	2009	ave p	1. pa	Kel							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death 200^{Year} **Physician** HOWELL August MARJORIE В. 12:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Village Care & Rehab Gaithersburg Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday **Funeral** Months Days 579-16-9796 86 Director Dec. 3 1922 Washington, D.C. Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 No Md. Montgomery Damascus Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Is marked other than "natural", or Items 23a or traumatic event, the Medical Examiner must be a 20872 United States 10428 Maynard Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black. White, etc. 72 hours after 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Restaurant 1 and 2 should be filed wi Health and Mental Hygien em 27 Is marked other th 10 Cashier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles M. Thomas Virginia Payne 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 Is
any Injury or other trau 10428 Maynard Court, Damascus, Md. Charlene Robinson / Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Cemetery 8/11/09 Rockville, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Muriel H. Barber Funeral Home muriel H. Barker P. O. Box 5038, Laytonsville, Md. 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed and Due to (or as a consequence of): Box 68760, physician Physician/Medical the attending IF FEMALE use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. the detached 9 Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by þ 1 Yes 2 No 3 Probably 4 Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autops, performed certificate 1 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred : After Certification: To the Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a To the Funeral C filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) PRACATOTIMATION PRO 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who sempleted cause of death (Item 23a) (Type, Print) Hargaret Hammersla CRMP 19529 Doctors Drive 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 10 2009 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 2017 M AUGUST 8 2009 DANIEL DAVID HARTKE, SR. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS 8. Date of Birth (Month, Day, Year)

DECEMBER 28, 1938 WASHINGTON, D.C. 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) **Funeral** Hours Months Davs 1 M 2 □ F 70 Director 579-50-4235 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location th and Mental Hygiene. 71 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director **MARYLAND QUEEN ANNE'S** CHESTER 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with UNITED STATES 307 SKIPPER LANE 21619 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after 1 जिYes 2 □ No If Yes, Give Year or Dates: **1961–1962** 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: WHITE ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) **FEDERAL** Elementary/Secondary (0-12) College (1-4or 5+) **GOVERNMENT** ELECTRICIAN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ELLEN DOODY ၉ JOHN JOSEPH HARTKE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ant of Health a t; If item 27 is y or other trau SYLVIA HARTKE/WIFE 307 SKIPPER LANE, CHESTER, MARYLAND 21619 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition AUGUST 15 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 2009 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE CEMETERY STEVENSVILLE, MARYLAND 21. Sign Te o Fyneral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ⁷hysician disease or condition resulting in death) /Medical as a consequence of) Examiner Sequentially list conditions Due to (or as a consequence of): Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): P.O. Box 68760 attending physician for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≨ 3 Probably 4 Unknown ficate has been signs, page 2 should b 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed certificate 1 ☐ Yes 2 ☐ No 1 Tyes director, 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient 2 ER/Outpatient 3 DOA 1 Yes Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27, Manner of Death 28c. Injury at Work? After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director; filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) manner stated. within 2. the 29d. Date signed (Month, Day, Year) 29b. Signature 2 113 ame and addre 31. Date filed (Month,

State

Registrar

2009

PITC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 1645 PM 2000 0000 42CMOUN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Annapolis Anne Arundel Medical Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/03/1949 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months Days Hours 1 □ M 2 👿 F 579-68-5002 59 Washington,D.C. **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it a Modical Examiner must be notified at angle. 10h. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ▼ No Directo Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21037 United States 3517 S. River Terrace Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 📈No þ If Yes, Give Year or Dates: Specify. White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Receptionist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edna Viola Bradley George Francis Talbert ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3517 S. River Terrace, Edgewater, Maryland 21037 19a. Informant's Name/Relationship (Type. Print) David W. Hermann/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Kalas Crematory 08/08/2009 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Funeral Service Licensee 2973 Solomons Island Road, Edgewater, MD 21037 23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final +LAS LUNCIC disease or condition resulting in death) Muc Due to (or as a consequence of): Completed by Physician/Medical Examiner Be

Physician /Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed

Baltimore, Maryland 21215-0036

nours after death.

neral Director: After this y filled in by the funeral di

Division of Vital Records, P.O. Box 68760,

Cognentially list conditions	b	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):	
resulting in death) Last	Due to (or as a consequence of):	
_	. d	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	23d. Date of delivery Month Day Year
Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
		1 Yes 2 INO 3 Probably 4 Onknown
		24a. Was an 24b. Were autopsy findings available
		autopsy performed? prior to completion of cause of death?
		l Yes 2 No 1 Yes 2 No
25. Was case referred to medical examiner?	26. Place of Death (Ch	eck only one)
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death	28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. I	Describe how injury occurred
1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation		
3 Suicide 6 Could not be		ocation (Street and Number or Rural Route Number,
4 ☐ Homicide determined	building, etc. (Specify)	City or Town, State)
	nysician: To the best of my knowledge, death occurred at the time, date and place, and	
(Check only 2 Medical Exar	niner: On the basis of examination and/or investigation, in my opinion, death occurred at	the time, date and place, and due to the cause(s)

29c. License number

065272

300 Annioghs, MO

29d. Date signed (Month, Day, Year)

State Registrar

Medical Certification: To

29b. Signature and

itle of certifier

Lalesa

900

Name and address of person who

31. Date filed (Month, Day, Year)

within 24 hours a

npleted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2009 10:47 A M Aug. Martha Louise Johnson 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Ceci1 Rising Sun Calvert Manor Healthcare Center If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Days Hours 1 □ M 2 🔀 F 74 Yrs Mar. 17, 1935 215-32-6992 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2X No Conowingo Maryland Cecil 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21918 USA 225 Johnson Rd 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Martha Elvira Barker William Walter Absher 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 225 Johnson Rd., Conowingo, MD Clinton Lee Johnson, Jr./Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Conowingo Baptist Cemetery Conowingo, Maryland Signature of Funeral Service License ²²R. T. Foard Funeral Home, P.A. 111 S. Queen St., Rising Sun, MD 21911 Approximate Interval Between Onset and Death 23a. Part . Enter the disease, or compl shock, or heart failure. List only or aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequent of): Sequentially list conditions, it any series in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown Month 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 ☐ Yes 2 No

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

28a-f show notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be a

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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Examine

Physician/Medical

Completed

Be

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Certification:

Medical

attending physician for use as the buria Hospital or Attending Physician: After

The law requires that the death certificate be execute

Division or Vital Records, P.O. Box 68760,

23b. Was decedent pregnant

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

26. Place of Death (Check only one)

25. Was case referred to medical examiner? 1 🗌 Yes 27. Manner of Death

5 Pending investigation 6 ☐ Could not be

determined

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of (Month, Day Year) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

29a. Certifier

1 Natural

2 Accident

3 ☐ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gloria Simonson, M.D., 111 W. High St., Suite 302, Elkton, MD

State Registrar

32. Registrar's Signature 31. Date filed (Month, Day, Year)

within 24 hours after deatl To the Funeral Director:

To the

10

completely filled

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 9:40 A M 10 2009 Jean Potter Klotzbach August /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 5239 W. Running Brook Rd Apt 101 Columbia Howard Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/20/1921 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 F New York 88 Director 069-18-5543 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c, City, Town or Location 28a-f show traumatic event, the Medical Examinar must be notified at 1 □Yes 2 TXNo Director MD Columbia Howard 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a or United States 21044 5239 W. Running Brook Rd Apt 101 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. or items 12. Was Decedent Ever in U.S. 11. Marital Status 72 hours after 1 ∐Yes 2 TNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify: Specify: \$ 3 ☐ Widowed 4 ☐ Divorced White "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 12 should be filed w h and Mental Hygier ' is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Genevieve Potter Stafford Floyd Howland Stafford ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 and 2 s Health ar em 27 is 5239 W. Running Brook Rd Apt 101, Columbia, MD 21044 Lewis E. Klotzbach / Husband permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr 3altimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/14/2009 Owings Mills, MD Garrison Forest Vet. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Dala Physician neumoned /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons be executed Exami and burial-tran Due to (or as a consequence of): physician Box 68760 Physician/Medical the, as attending for use a IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) o 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy certificate 1 □Yes 2 🖾 No 1 🗆 Yes Vital 2 ∏ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA 1 Inpatient ō After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred ie Hospital or Attending P n 24 hours after death. ie Funeral Director: After t 28c. Injury at Work? Certification; Division 1 XNatural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1250870 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) darlesulle MD 2,029 31. Date filed (Month, Day, Year) **AUG 11** Registrar

DHMH 17 Rev 1/2001

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Michael	Koory

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	-	For State egistrar	•		Certific	ate of	Death					Reg. No.	(L U		4100
Physician Iedical Examine	1	Decedent's Name (First, Middl Michael	e,Last)	Koor	у						Date of De Month August 1	1, 2009		21	ne of Death 10 hrs
	4	a. Facility Name (if not institution Franklin Square Hosp	=	umber)		4	Roseda		cation of	Death			County of Do altimore C		
Funeral Director		5. Social Security Number	6. Sex	7. Age (ir	n yrs. last bir		Months Days Hours Min. Nov. C				Birth (MM/D		Country)	e (State or Foreign	
51100101	\perp	578-92-6200 Jsual Residence of Decedent	1XX M 2 F			Yrs	1				1101.	, 150			
any	_	0a. State 10b. County		100	c. City, Town	or Locati	on								Inside City Limits
Maryland 28a-f show d at once.	Maryland Baltimore Essex										Yes 2 X No				
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene, 7 is marked other than "natural", or items 23a or 28a-f sho rate wort, the Medical Examiner must be notified at once.	2 1 2 1	Oe. Street and Number 952 N. Marlyn		10f. Zip Code 21221						U	og. Citizen of What Country? USA				
s 23a c	<u>8</u>	11. Marital Status	12. Was De	cedent Eve	er in U.S.	13. Wa	s Decedent			in? (Spec	cify Yes or N		14. Race - A		dian, Black,
r item	nuera	1 Never Married 2 XX	Armed F		No	If Y	es, specify	Cuban, I	Mexican,	Puerto R	ican, etc.)		White, etc.		
s after c			orced If Yes, Give Ye or Dates:			1	Yes 2 X	- A		ind of wo	rl: dono		Specify: ind of Busin	White	_
"natural Examin		15. Decedent's Education (Spe Elementary/Secondary (0-12)		(1-4 or 5+)	eted) 16a		ost of worki					TOD. K	ing or basin	633/11/030	
21215-0036 ould be filed within 72 Mental Hygiene. s marked other than " ic event, the Medical	Сощрієте	12	Johnson	(,	In	Installation Supervisor Security So							Solut:	ions	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica		17. Father's Name (First, Middle				18.Mother's Name (First, Middle, N							· ·		
121 Id be fi fental narked event,	e e	John Koory	Sr.		110	9h Mailin	Address		Charle		Rose		Badzik		
MD 2 d 2 shoulth and N n 27 is n numatic	19a. Informant's Name/Relationship (Type, Print) Nam Koory – Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 952 N. Marlyn Avenue Exxex, Maryland 212														
imore, MD 21215-0036 Pages I and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than " To Do Commelled		20a. Method of Disposition 1 xx Burial 2 Cremation	o [] B	Ohata		of Dispos	sition (Name	of cem	etery,		Date	20c. L	ocation - Ci	ty or Town	, State
Pages nent of ant: If		4 Donation 5 Other S	pecify:	nom State	Mary1a	-		tery		08/19	9/2009	Ch	eltenha	am, Ma	ryland
Baltimore, permit. Pages 1 an Department of Hea Important: If ite injury or other tra		21. Signat of Funeral Service	Licensee		22. Name and Address of Facility George P. Kala 6160 Oxon Hill Road Oxon Hill, Ma							alas Funeral Home P.A. Maryland 20745			
Physician	- 1	23a/ Part I. Enter the disease, or	r complications that	caused the	e death. Do i								-	Ap	proximate Interval
/Medical		Mailure. List only one cause Immediate Cause (Final disease	e on each line.											В	etween Onset and Death
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	Ę∤	cause. Enter Underlying Cause (Disease or injury that initiated	c. Due to (or as	a conseni	ence of):										
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8760, ifficate be g physici s the buri		IF FEMALE: 3b. Was decedent pregnant in t		, outcome birth	of pregnanc	y 2 Fe	etal death	3	Ectopic	pregnan	ісу	230	d. Date of de Month	elivery Day	Year
Box 68: death certiff the attending de for use as	Sicia	past 12 months? 1 Yes 2 No 9 Ur	4 Pres	gnant at tin	ne of death		ther (Speci					- 1			
that the dea ned by the a detached for	Physician	Part II. Other significant condi	9 Onk	nown to death b	ut not result	ing in the	underlying (cause gi	ven in Pa	art I.	23e. Di	d tobacco	use contribu	ite to the c	ause of death?
P.O.	2										1	Yes 2	No 3	Probably	4 🗸 Unknown
Division of Vital Records, tal or Attending Physician: The law require is after death. In Director: After this certificate has been si led in by the funeral director, page 2 should be in the funeral director in the	Completed										24a. W au	as an itopsy	prie	or to comp	y findings available letion of cause of
Reco	E O										1 ✓ Ye	erformed? es 2 N		eth? Yes	2 No
tal Rection: The certificate	Be	25. Was case referred to medic examiner?	al Hospital:					1/	of Death Other:	(Check c					
F Vit	의-	1 ✓ Yes 2 No 27. Manner of Death		Inpatient te of Injury		Outpatien Time of		,,	y at Work	`	Home 5		ury occurred	Other:	*
ion of tending Ph	<u></u>	1 V Netural	(Mor	nth, Day,Yea	r)		,,		es 2	_		,	,		
VISIC or Atte ter dea birector	lica		estigation 28e. Pla	ace of Injur	y - At home,	, farm, stre	et, factory,	office b	uilding, et	tc.			and Number	or Rural F	Route Number, City
Divis spital or At cours after defined in by filled in by	Certification:	4 Homicide det	ermined (Specif					or Town, State)							
Division To the Hospital or Attend within 24 hours after death To the Fineral Director: completely filled in by the	- 3	29a. Certifier 1 Certifying F (Check only one) 2 Medical Ex	Physician: To the basi	est of my k s of examin	nowledge, on ation and/o	death occu or investiga	irred at the ation, in my	time, da opinion,	te and pla death oc	ace, and ccurred at	due to the c t the time, d	ause(s) ar ate and pla	nd manner a ace, and du	is stated. e to the ca	use(s)
To the within 2 To the complet	Medical	29b. Signature and title of certif	and manne	stated.	-				e number				Date signed		
		alle &	rand 1	N	-			O.C.	И.Ε.			Aug	gust 12, 2	2009	
	+	30. Name and address of person					Dow = 01		_147:	- 1/0	04004				
		Melissa Brassell, MD		ledical E		111	Penn Str	eet, B	altimor	e, MD	21201				
Sta Registr		31. Date filed (Month, Day, Year	2000	. agistici s	A	Sau	end .								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 5, 2009 Year Month **Physician** РМ 2:00 August Dale Lee Harry /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Salisbury

Winder 1 Year 1 If Under 24 Hrs. Wicomico 806 Parker Rd 8. Date of Birth (Month, Day, Ye 2/3/1926 9. Birthplace (State or Foreign Country) 6 Se 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 MM 2□ F Yrs. 275-22-1528 Ohio 83 Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 1∩a State 28a-f show ed other than "natural", or Items 23a or 28a-f shovevent, the Widow Evanior must be notified at 1 ☐ Yes 2 No Director Salisbury Maryland Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filled within 72 hours after death with nent of Health and Mental Hygiene.
ant; If item 27 is marked other than "natural", or Items 23a or USA 21804 806 Parker Rd. Funeral 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: Navy 1 ☐ Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Day Zimmerman Linesman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be Department of Health and Menta Important; If item 27 is marked an injury or other traumatic evons. Bessie St. John ဥ Bert Lee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 26617 Nanticoke Rd., Salisbury, Maryland 21801 Michelle Osborne/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Eastern Shore Maryland Date 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Hurlock, Maryland 4 Donation 5 Other (Specify) 8/10/2009 Veterans Cemetery nature of Funeral Service Licensee 2HOTTOWAY FUNETAL Home P.A. Company that caused 501 Snow Hill Rd. Salisbury, Maryland 21804 4. Jarrie CFSP 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final vears **Physician** disease or condition resulting in death) ASCVD /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of) P.O. Box 68760. physician Physiclan/Medical the as attending | for use as IF FEMALE: 23c, If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Day 5 Other (specify) ☐Yes 2☐No sate has been signed by the page 2 should be detached 9 I I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Tyes 2 No 3 Probably 4 3Unknown Pneumonia, Diabetes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day, Year) 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director; 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) by 4 Homicide filled in I

Division of Vital Records, 24 hours a the

within 24 hor To the Fune completely f 10 State

29b. Signature and title of certifier erson who comply d cause of death (Item 23a) (Type, Print) 30. Name and address

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

203 SHOW STI SNOW HILL MD SIBER

AUG 0

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Registrar

29a. Certifier

(Check only one)

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 200^{Year} 1:15 A M August 8, RUTH LEE NAOMI 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Somerset Crisfield Alice Byrd Tawes Nursing Home If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days Hours Months 1 □ M 2√ F 24, 1933 Marvland 214-32-1311 Jan. 76 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ¥Yes 2 □ No Crisfield Maryland Somerset 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21817 294 Somers Cove Apartments Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Black, White, etc. Armed Forces 1 ∏ Yes 2 Two No. If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clothing Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Irene Killman John DeHaven 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4197 Paul Gunby Road - Marion Station, MD Carolyn E. Cullen (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Sunnyridge Memorial Park 8/10/09 Crisfield, MD 4 □ Donation 5 □ Other (Specify) 21. Signature Suner Service License Robert H. Bradshaw, Jr 22. Name and Address of Facility Bradshaw & Sons Funeral 306 W. Main St. - Crist Crisfield, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 DEctopic pregnancy Month Day 5 Other (specify) 4☐Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? /es 2 \sum No 1 Yes 2 🗌 No 1□ Yes 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 28a. Date of Injury 28h. Time of 28c. Injury at Work? (Month, Day Year) 5 Pending investigation 1 ∏Yes 2 □ No

Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

Funeral

Director

items 23a or 28a-f show ner must be notified at

'natural', or items 23a dical Examiner must

event, the Medical than "

permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 is marked other i any Injury or other traumatic event, <u>th</u>

within 72 hours after

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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The law requires that the death certificate be executed burial-trar physician the for use ed by the a detached f signed t page 2 certificate Hospital or Attending Physician: funeral director, After this

Division or Vital Records, P.O. Box 68760,

Physician/Medical <u>}</u> Be Completed

Certification: To

within 24 hours after death

To the Funeral Director:
completely filled in by the

2 State

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Yes 2 XNO 27. Manner of Death 1 Natural 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier

29c. License number

HALL HIGHWAY,

29d. Date signed (Month, Day, Year) 2009

CRISFIELD, MD, 2817

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. VIJAY KARUMBUNATHAN

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

(Check only

32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Lee McNey Bertha 2009 12:15 A.M. Aug 6, /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Future Care Pineview Nursing Home Clinton If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1□M 2√X 87 578 18 3534 April 22, 1922 Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 28a-f show 1 ☐ Yes 2XXNo MD P.G. Clinton notified Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number a or 20735 9106 Pineview Lane United States d 2 should be filed within 72 hours after death with and Mental Hygiene. 77 is marked other than "natural", or Items 23a traumatic event, the Medical Examiner must b Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XXNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2√CNo Specify Specify: White Completed by 3 Vidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Industry Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Saunders Marion Wines 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traun 4105 Atmore Place, Temple Hills, MD 20748 Margaret Clements (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery Aug 10,2009 Suitland, MD f Fuderal Service Licensee 22. Name and Address of FacilityLee Funeral Home, Inc 6633 old 21. Signatur Alexandria Ferry Road, Clinton, MD 20735 23a. Pant. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, set and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 🕅 No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. May er of Death 1 Natural 28a. Date of Injury 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division or Vital Records, P.O. Box 68760,

To the Func To the I within 2.

State Registrar

Medical

29a, Certifier

(Check only one)

29b. Signature and title of certifier

29c. License numbe

t 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who o'mpleted cause of death (Item 23a) (Type, Print)

Laxmi Berwa, M.D. 7700 Old Branch Ave Suite Clol, Clinton, MD 20735

31. Date filed (Month, Day, Year) AUG 10 2009 32. Registrar's Signature Deneur

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Aug 9, 6:30 P M Miley 2009 Wilomina Grace /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charles Fenwick Landing Senior Care Waldorf If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country)
New Jersey 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Vear Days 1 □ M 2**X**XF 85 May 6, Director 145 18 8904 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaruiner must be notified at 1 ☐ Yes 2 No Director MD Charles Waldorf 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 11655 Doolittle Drive 20602 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White etc. 1 ☐ Yes 2 TVNo If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2□No XX Specify White Specify: 3 3)(Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Defense Department Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Grace Tempone Edward Woelpper ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 42289 Allison Drive, Mechanicsville, MD 20659 Wayne Raley (Friend) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Maryland Veterans Cemetery 2009 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 21. Sign mure of Funeral Service Lidensee Approximate Interval Between Onset and Death 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one pluse on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit and Due to (or as a consequence of): nding physician are as the burial Box 68760. The law requires that the death certificate be Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day jo 1 Yes 2 No 9 Unknown 5 ☐ Other (specify) signed by the a o. 9 ☐ Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 1 ial or Attending F is after death.

al Director: After ed in by the funera 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital of the Hours a To the Hospital of within 24 hours a To the Funeral D 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) 30. Nime and address of person 1100 14 7 31. Date filed (Month, 32. Registrar's Signature State Registrar

			For State Registrar	State of Ma	aryland /	•	artment of H tificate of I		nd Mental Hy	giene Reg. No.	009	27038
	Dhysioi	an	1. Decedent's Name (First, Middle, Las	t)					2. Date of De Month	ath Day	Year	3. Time of Death
	Physicia /Medic		Charles E. Martin	Jr.					08	05	2009	2045 pm
	Examin	er	4a, Facility Name (If not institution, give	· mad.	1001	121	4b. City, Town, or	Location of I	Death	4c. Cc	ounty of Death	4.5
194			5. Social Security Number 6. S	al Medit	e (In yrs. last	hirthday)	If Under 1 Year	Spury If Under 24	Hrs. 8 Date of Bir	<u> </u>)/Com/	lace (State or Foreign
	Funeral Director			⊠ M 2□ F	66	Yrs.	Months Days		Min. 8. Date of Bir (Month, Date 3/14/19	iy, Year) 943	Mary]	ntry)
			Usual Residence of Decedent						[0, = 1, =		mar À-	land
	rylan how	_	10a. State 10b. County		10c. City, To		cation				1	0d. Inside City Limits
	Ba-fs	cto	Maryland Wicomic)	Salis	bury						1 A Yes 2 □ No
	章 g 章	Director	10e. Street and Number				10f. Zip Code				n of What Cour	ntry?
	ath w		400 Buena Vista A			1,0	21804		0./0	USA	D A	and the street
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Model Exemi	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 🔼 If Yes, Give Year or Dates:		'	was Decedent of H f Yes, specify Cuba I □Yes 2 ☑ No	Specify:	n? (Specify Yes or No Puerto Rican, etc.)		. Race - Americ Black, White, o becify:	etc.
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Maryland	2 sho n and is ma rauma		19a. Informant's Name/Relationship (or Rural Route Numb	-	•	
	Tand 2 Health a tem 27 i	- 69	Brenda Martin/Ex-	wife					isbury, M.		tion - City or To	
Baltimore,	Pages 1 nent of H ant: If ite ury or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	1		sition (Name of natory or other place				,	
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Ba	permit. Pages Department of Important: If i any injury or once.	Ų į	21. Signature of Emeral Service Licer	Blan	ul	<u> </u>	Name and Addre	Tuneral HIII Ro			aryland	
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- de	/Medical Examiner		resulting in death)	Due to (or as	a consequenc	ce of):						
		<u>~</u>	Se uentially list conditions	b. Due to (or as	a consequent	ce on:						
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		Medi	JE 55144 5					-				- 3
Вох	eath certific attending p for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 \square Live birth	of pregnancy		Ectopic pregnanc	V		23	d. Date of deliv	-
O.E	e dea the at red fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant a 9 ☐ Unknown	t time of death		Other (specify) _				Month	Day Year
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E.	The ate h page	ĕ							perfo 1 □ Yes	ormed? 2 No	death? 1 ∐Yes	212No
Vital	rsician: The law s certificate has b lirector, page 2 sh	Be (25. Was case referred to medical examiner?						f Death (Check only	one)		
of \	Physi r this c ral dire	၉	1 Yes 2 No	Hospital: 1 Inpatie		<u> </u>	nt 3 DOA Oth	4 🗆 INUIS	ing Home 5 ☐ Res			fy)
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Sic	vttendi death. ctor: / the fu	icat	2 Accident investigation 3 Suicide 6 Could not be		un. At homo	form of	1, = -	Yes 2 □ No		(Street and	Number or Rum	al Route Number,
Division	al or A s after I Directed in by	Certification:	4 ☐ Homicide determined	building, et	c. (Specify)	, 10.1111, 31.1	eet, factory, office			wn, State)	variber of Hare	ar Houte Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical C		ysician: To the best niner: On the basis o and manner sta	f examination							
	To the Ho within 24 h To the Fur completely	Me	29b. Signature of title of certifier				29c. Licens	e number		29d. Date	signed (Month,	Day, Year)
	Q		Mahrh	W/	MI	9	D6	0515	^	8/	6/04	
	$\mathcal{F}_{\mu,}$		30. Name and address of person who	completed cause of d	eath (Item 23	a) (Type,	Print)			-/	- / /	
			M.THIMMARAY	48817 61	14 B	EMI	TEKN X	PRED	R SALLS	BURI	MD	71804
	Sta	ite	31. Date filed (Month, Day, Year)		ar's Signature	4	0.41				•	
	Registr	ar	AUG 0 7 2	009 Prose	in p	1. J	CERTERS					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year 5:55 AM 2009 McCa11 Availst Edith Marie 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Hours 1 □ M 2 🔀 F Months 69 Feb. 20, 1940 Virginia 315-38-1886 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 1 X Yes 2 No Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 18612 Carolyn St. 21742 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 □Yes 2 🗓 No Specify: Specify. 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cook Food Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bertha Puckett Arnold Moses 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 33 E. Church St., Williamsport, MD 21795 Bradley E. Grant/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 8/22/2009 Hagerstown, MD Rest Haven Cemetery 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Severe Due to (or as a consequence of): unnary muc resulting in death) - Q - Waye Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Preum 23d. Date of delivery yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Tectopic pregnancy Year Month 5 ☐ Other (specify) ☐Yes 2 ☐NO 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown mrey 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 ☐ Yes 2 4NO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 27. Manner of Death

Physician /Medical Examine

permit. Pages 1 and 2 should be filed wif. Department of Health and Mental Hygient Important: If item 27 is marked other the any injury or other traumatic event, I'mal once.

Physician

/Medical

Examiner

Funeral

Director

show

Director

Funeral

Completed by

Be

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7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the warden Experient aut be notified at

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division of Vital Records,

Examine The law requires that the death certificate be executed the attending physician and hed for use as the burial-trar

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death.

e Hospital or Attendi 24 hours after death. e Funeral Director; A

To the I within 2 To the I

Physician/Medical Completed by

Be

Certification:

Medical

IF FEMALE:

28b. Time of

28c. Injury at Work?

28d. Describe how injury occurred

Itagierstown

(Month, Day, Year) Injury 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 PNatural

2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

5 Pending

investigation

determined

6 ☐ Could not be

29c. License number D62588 29d. Date signed (Month, Day, Year) 164, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Antietom St. E. 251

MBAOUA JUDITH 31. Date filed (Month, Day, Year) AUG 24

32. Registrar's Signature

State Registrar

			1 – For State Registrar	State of Maryl		epartment of H Certificate of L			ene g. No 2009	27040
	Dhuaisi		1. Decedent's Name (First, Middle, La.	st)				2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		DONALD		M	IARSTELLER		AUGUST	17, 2009	8:55 P M
	Examin	er	4a. Facility Name (If not institution, giv FOREST HILL HEAI		ENTER		Location of Death REST HILI		4c. County of Deat	
	Funeral		5. Social Security Number 6. S	ex 7. Age (In	yrs. last birtho	(ay) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9 Birt	hplace (State or Foreign
	Director		ZT/=0)-T0T4	XM 2□F	90 Yr	s. Months Days	Hours Min.	(Month, Day, 7/23/1	919	Maryland
	and w		Usual Residence of Decedent 10a. State 10b. County	100	. City, Town o	or Location				10d. Inside City Limits
	Mary Ind	후	MD. Harf	ord.		Jarre	ttsvill	.e		1 ☐ Yes 2 📉 No
	or 28g	Sire	10e. Street and Number			10f. Zip Code			g. Citizen of What Co	untry?
	death with the Maryland ims 23a or 28a-f show	la	1129 Baldwin	Mill Road			21084			States
	items	Funeral Director	11. Marital Status 1 ☐ Never Married 2 X Married	12. Was Decedent Ever i Armed Forces? 1 No	n U.S.	 Was Decedent of Hi If Yes, specify Cuba 	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
2-003b	I within 72 hours after death with the Marylan ijen. Itan." The Medical Evaminar must be notified at	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates: W	W II	1 ☐ Yes 2 No	Specify:		Specify: W	hite
<u>က</u>	72 ho	eted	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. D	ecedent's Usual Occupa	ation Juring most of work	kina 1	6b. Kind of Business/	Industry
7	within iene. than "I	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	` <i>i</i>	ife. DO NOT use retired Electri)		Elect	rical
7 0	ë ₹ ë t	ပ္ပိ	17. Father's Name (First, Middle, Last,			Frecur		e (First, Middle, M		11001
land		To Be	Thomas]	Marst	eller	Luc	У	St	iteyl
<u> </u>	and and sum		19a. Informant's Name/Relationship (Type. Print) (Wife	/	-				Zip Code) 21084
2	D = C =		Virginia T. Ma			29 Baldwi				ille, MD.
E E	ages 1 nt of H : If ite		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐	Removal from State	cemetery,	isposition (Name of crematory or other place	e)		Oc. Location - City or	
ащи	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other		4 ☐ Donation 5 ☐ Other (Specifical Signature of Funeral Service Lice)		arrol	1 Cremati 22. Name and Addres				, Maryland
מ	Depar Depar Impor any ir		Malerely	en Kunta	200	Home, P.	و نند		z & Son ille, Ma	
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the cone cause on each line.	death. Do no					Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	COPD						Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a con	sequence of)	:				
		ē	Sequentially list conditions, if any, leading to immediate	b Due to (or as a con	sequence of)	:				
X	cuted nd ransit	Examiner	cause. Enter Underlying Cauce (Disease of Injury) that initiated events	C.						
2,0078	icate be executed physician and the burial-transit	Ë	resulting in death) Last	Due to (or as a con	sequence of)					
0	icate be execute physician and s the burial-trans	dical		d						
XOD	leath certific attending p		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre					23d. Date of de	livery
Ď	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/M	in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ I 4 ☐ Pregnent at time 9 ☐ Unknown		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	/		Month	Day Year
7. O	at the d by the etache	Phys	9 Unknown		(4: : . 4)		on in Don't	22a Did tob	acco use contribute to	the cause of death?
S,	signe signe d be d	Š	Part II. Other significant conditions of	ontributing to death but not	resuling in a	ne underlying cause give	mmraiti.		s 2 No 3 P	
ecords,	v requ	Completed	7					24a. Was an	24h Were au	utopsy findings available
T T	he lav le has age 2	dmc	- 4 file					autopsy perform	prior to death?	completion of cause of
g	ian: T	Be C	25. Was case referred to medical				26. Place of Dea	1 □ Yes 2 th (Check only one		2 No
> 5	hysic this ce al direc	To E	examiner? 1 Yes 2 No			atient 3 □ DOA Othe	4 Li Nursing H	ome 5 ☐ Reside	nce 6 ☐ Other (Spe	ecify)
	ding Prysician: The law requires that the de n	ion:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day, Yea	28b. Tir Inji	iry Work	yat ⟨? Yes 2 ∐No	28d. Describe ho	w injury occurred	
ISION	Attend death ctor: by the	fical	2 Accident investigation 3 Suicide 6 Could not b		At home, farm		res 2 🗆 No	28f. Location (Str	eet and Number or R	ural Route Number,
2	al or safter	Certification:	4 Homicide determined	building, etc. (Sp	oecify)			City or Town	, State)	
1	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p	edical (nysician: To the best of my niner: On the basis of examination and manner stated.						
	To the within To the comple	Me	29b. Signature and title of certifier			29c. License	e number	29	d. Date signed (Moni	th, Day, Year)
h	•		1 David 5	2		1232	3255	<	my 15	2005
		1	30. Name and address of person who			ype, Print)			N - 0	
			DAVID DUNN - 6	15 W. MACPHA		AD - BEL	AIR, MD.	21014		
	Sta Registr		AUG 2 4 200		A. 4	and				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

		-	For State Registrar	e or iviaryia		rtificate of l	ieaith and iv D <i>eath</i>		eg. No.	19	27041
	Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month	Day 14/2009	Year	3. Time of Death
	/Medic	al		ARKE McH	UTCHISO		Location of Death	8/	14/2009 4c. County of	of Death	8:30 A M
	Examin	er	4a. Facility Name (If not institution, give street and WILLIAM HILL GA			4b. Oity, Town, of	EASTON		lo. county		BOT
	Funeral Director		5. Social Security Number 145-38-6965 6. Sex 1 □ M 2 🗷	_	s. last birthday) 5 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 10/21	Year) /1913	9. Birthp Coun	lace (State or Foreign try) GEORGIA
	and		Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Lo	cation				1	0d. Inside City Limits
	a-f sho	ctor	MARYLAND TALBOT			ST	. MICHAEL				1XYes 2 No
	th with the 23a or 28	ral Director	10e. Street and Number 7188 DRUM P	Γ. RD.		10f. Zip Code	21663		0g. Citizen of W	US	4
980	be filed within 72 hours after death with the Maryland tial Hyglene. id other than "natural", or items 23a or 28a-f show event, I'v. McGel Eraning rust to ruited at	by Funeral	1 Never Married 2 Married 1 Yes	Decedent Ever in I d Forces? 'es 2 X No , Give or Dates:		Was Decedent of H If Yes, specify Cuba 1 □Yes 2 🗷 No	ispanic Origin? (Sp un, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)		k, White, (ean Indian, etc. WHITE
Maryland 21215-0036	hin 72 hou e. an "natura motical I	Completed	15. Decedent's Education (Specify only highest grade comple Elementary/Secondary (0-12) Colle	ted) ge (1-4or 5+)	1 (Give	DO NOT use retired	during most of work d)	ing	16b. Kind of Bu		
21	led with	Con	12 17. Father's Name (First, Middle, Last)			HOMI	EMAKER 18. Mother's Name	e (First Middle I			HOME
anc	ev de la	To Be		N CLARKE			To. Modici 5 Ham.		Е ТНОМІ		
ary	s 1 and 2 should be i f Health and Mental item 27 is marked o other traumatic eve	-	19a. Informant's Name/Relationship (Type. Print)		19b. Mailir	•	and Number or Rui				
	1 and Healt em 27 ther 1		JAMES E. McHUTCHISO		. Place of Dispo	PO BO esition (Name of matory or other place	OX 171, SOU	Date Date	20c. Location -		
Baltimore,	ë ± 5		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal 6 4 ☐ Donation 5 ☐ Other (Specify)	rom State i	D SHORE CI	REMATION CE	NTER 8/1:	5/2009	CAN	MBRII	OGE, MD
Ball	permit. Pag Departmen Important: any injury once.		21. Signature of Funeral Repvice Censee	2		2. Name and Addre ID SHORE CRI		TER, 2272 HU	UDSON RD.,	CAMB	RIDGE, MD 21613
	Physician		23a. Part 1. Enter the disease, or complications t shock, or heart failure. List only one cause Immediate Cause (Final	hat caused the decon each line.	ath. Dim ent	ter the mode of dying	ng, such as cardiac	or respiratory are	rest,		Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	e to (or as a conse	equence of):						
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89 x	sertifica ding ph se as th		IF FEMALE: 23c If yes	s, outcome of preg	inancy				23d Dat	te of deliv	erv
P.O. Box	Attending Physician: The law requires that the death cert in death. In death. Sector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use a by the funeral director, page 2.	Physician/N	in the past 12 months?	Live birth 2 Fe Pregnant at time o Unknown	etal death 3	☐ Ectopic pregnand ☐ Other (spec <i>ify</i>) _	-			nth	Day Year
ds, P.	uires that signed by Id be deta	ξ	Part II. Other significant conditions contributing	to death but not re	esulting in the u	inderlying cause giv	en in Part I.				he cause of death? bably 4 🔲 Unknown
ocol	ie law requires t has been signe ge 2 should be o	Completed						24a. Was a	sv l	Were auto	opsy findings available ompletion of cause of
<u>~</u>	: The cate h	Com							rmed?	death?	2 No
<u> </u>	sician s certifi irector	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital:	1 ☐ Inpatient 2	☐ FR/Outpatie	nt 3 DOA Oth	26. Place of Dea	th <i>(Check only o</i> o ome 5 ☐ Resid	-	er (Spec	ifv)
n of	ng Phy fter this neral d	on: To	27. Manner of Death 28a.	Date of Injury (Month, Day, Year)	28b. Time o	of 28c. Inju Wor	ry at		now injury occur		
Division of Vital Records,	or Attendii ifter death. Director: A in by the fu	Certification: To	2 Accident investigation 3 Suicide 6 Could not be 28e.	Place of Injury - At building, etc. <i>(Sp</i> e	home, farm, st ec <i>ify)</i>]Yes 2 No	28f. Location (5 City or Tow		er or Rui	al Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical Ce	29a. Certifier (Check only one) Certifying Physician: 2 Medical Examiner: One one	To the best of my k the basis of exam manner stated.	knowledge, dea ination and/or i	th occurred at the t nvestigation, in my	ime, date and place opinion, death occu	e, and due to the irred at the time,	cause(s) and m date and place,	anner as and due	stated. to the cause(s)
U	To the within To the Comp	Me	29b. Signature and title of certifier Matthew Fisher	MP		29c. Licen	se number		29d. Date signe	d (Month	, Day, Year)
			30. Name and address of person who completed Matthew 1950 were	2 Martin	COURT	Print) Easts.	n MAR	YLAND	216	501	
	Sta Regist		31. Date filed (Month, Day, Year) AUG 2 4 2009	32. Registrar's Sig	A. Sa	Kel					

	Physici /Medio Examin
)	
	Funeral Director
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Everning in 191 by Little at once.
	Physician /Medical
	Examiner
Division of Vital Records, P.O. Box 68760,	at or Attending Physician; The law requires that the death certificate be executed after death. I Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit.

		1. Decedent's Nam-	e (First Middle.	Last)								2. Date of De	ath			3. Time of	Death
sicia	n				ODLIGOD							AUGUST	Day	200		5:4	P M
edica	al .		VITA LAV			-		4h City	Tour	r Location o	of Dooth	MOGOSI	1	County of De		J • 4.	<u> </u>
mine	er	4a. Facility Name (i		_	a numper)			4b. City,								m t c	
		104 WEST			T =			If Unde		If Under				QUEEN		ce (State o	or Corolan
ral		5. Social Security N		6. Sex 1 □ M 2 🛣		-	t birthday) Yrs.	Months		Hours	Min.	8. Date of Bir (Month, Da	y, Year)		Countr	y) .	or Foreign
or		213-22-04				90	115.					APRIL	1, 191	9 M	AKY	LAND	
	}	Usual Residence of 10a. State	10b. County		10	c City	Town or Lo	cation							100	d. Inside Ci	itv Limits
	_	Toa. State				o. Oity,	101111 01 20	oation .									2 X No
	ಕ್ಷ	MARYLAND	QUE	EN ANNE	'S					NSVIL	LE						
	Director	10e. Street and Nu						10f. Zip	o Code					en of What (
	<u></u>	104 W	ESTVIEW	DRIVE						21666				ITED S	TAT	TES	
	Funeral	11. Marital Status		12. Was	Decedent Ever ed Forces?	r in U.S.	13.	Was Dece	dent of F	lispanic Ori	igin? (Sp	ecify Yes or No Rican, etc.)	- 1	 Race - An Black, Wh 			
	교	1 Never Marr	ied 2 Marrie	ed 1 □Y	es 2 No s, Give			1 □Yes	-	Specify:		, ,			HIT		
	ρ	3 X Widowed	4 Divorced	Year	or Dates:			1 🗆 103	2 (4.110	Opcony.				specify.			
	Completed	/600	15. Decedent	s Education	itad)			dent's Usu		oation during mos	t of work	ina	16b. Kin	d of Busines	s/Indu	stry	
	를	Elementary/Seco	cify only highes	Ť	ge (1-4or 5+)		life.	DO NOT u	ise retire	d)	t or work	ing					
	ē	10	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				P :	RACTI	CAL	NURSE			ST	ATE HO	SP1	TAL	
	Be	17. Father's Name	(First, Middle, L	.ast)						18. Mothe	er's Name	e (First, Middle	, Maiden S	Surname)			
	일		OLLIE	HOWARD								CORA I	OCKE'	ГT			
	-	19a. Informant's N	ame/Relationsh	ip (Tvpe, Print))		19b. Maili	ng Address	s (Street	and Numb	er or Rui	al Route Numb	er, City or	Town, State	, Zip C	Code)	
			A HANEKI				104	WFSTV	TEW	DRTVE	. 51	EVENSVI	T.I.E.	MARYT	ANT	216	66
-		20a. Method of Dis		J DROOM				osition (Na		DICTU		Date		ation - City			
		1 ☐ Burial 2	▼ Cremation			cen	netery cre	matory or CR	other niai	TON	AUGU	IST 10,					
			5 Other (Sp		\rightarrow		C	ENTER		- 1		2009		ENSVIL	_		
once.		21. Signature of Fu	une al Service I	icentee.	\		\mathbf{F}	2. Name a ELLOW	nd Addre	ELFEN	BEIN	AND NE	WNAM	FUNER	AL	HOME	, P.A
9			AKKEL		XIC	2	10	06 SH	AMRO	CK RO	AD,	CHESTER	R, MA	RYLAND			
		23a. Part 1. Enter	lease, or cart failure. List o	complications t	hat caused the	death.	Do not en	ter the mo	de of dyi	ng, such as	cardiac	or respiratory a	rrest,			Approxima Interval Be	tween
an		Immediate Cause	(Final		LIVE	Λ		VLE							'	Onset and	
al		disease or condition resulting in death)		a. Du	e to (or as a co	_											
er				50	10.	man									1	Man	12
	ᡖ	Sequentially list co	onditions,	b	e to (or as a co										+	7713	/ -
	듣	Sequentially list co if any, leading to in cause. Enter Unite Cause (Disease or	erlying 4	-	(3, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3												
	Examiner	that initiated events resulting in death)	S	c	e to (or as a co	neenue	nce of):								+		
		,			ic to (or as a oc	Jilooquei	1100 01).										
	an/Medical		,	d											+-		
	ğ	IF FEMALE:															
	au/	23b. Was deceden			s, outcome of p Live birth 2 D			☐ Ectopic	pregnano	су			2	3d. Date of a Month		-	Year
		in the past 12 1 ☐ Yes 2	No	4 🗆	Pregnant at tim Unknown		1	Other (s	15.1	-				MOTH		Jay	Teal
	اخِّ	9 Unknown		30	OTKHOWIT							-					
	Completed by Physic	Part II. Other signi	ificant conditio	ns contributing	to death but n	ot resulti	ing in the ι	ınderlying	cause giv	ven in Part I	l.	23e. Did	tobacco us	se contribute	to the	cause of	death?
	Ď D											1 🗆	Yes 2	(No 3□	Proba	ıbly 4 ☐	Unknown
	lete											24a, Was	an	24b. Were	autop	sv findinas	available
	ם											auto		prior death	o com	pletion of	cause of
	ပ္ပ											1 □ Yes	2/No	1 □ Y	es 2	2 □ No	
	Be	25. Was case reference examiner?	rred to medical	11					Lou		e of Deat	th (Check only	onel)				
	၉	1 ☐ Yes 2			1 Inpatient	-			OA		ursing Ho	ome 5 🛣 Res			pecify)	
	Ë	27. Manner of Dear	th 5 ☐ Pending	I .	Date of Injury (Month, Day, Ye	ear) 2	8b. Time o Injury	of	28c. Inju Woi	ry at rk?]	28d. Describe	how injury	occurred			
	aţi	2 Accident	investig	ation		1		М	1 🗆]Yes 2□	No No						
	i <u>l</u>	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could n determi	ned 28e. F	Place of Injury building, etc. (- At hom	e, farm, st	reet, factor	ry, office			28f. Location	Street and wn, State)	l Number or	Rural	Route Nui	mber,
	ert	4 🗆 i iomicide			building, etc. (e	Ороону						Only of 70	m, olalo,				
	<u>=</u>	29a. Certifier	1 Certifyln	g Physician: T	To the best of m	ny knowl	edge, dea	th occurre	d at the t	ime, date a	nd place	, and due to the	e cause(s)	and manne	as st	ated.	
	Medical Certification: To	(Check only one)	2 Medical I	Examiner: On and	the basis of ex manner stated	aminatio 1.	on and/or i	nvestigatio	n, in my	opinion, de	ath occu	rred at the time	, date and	place, and o	lue to	the cause((s)
	Me	29b. Signature and	title of certifier					29	9c. Licen:	se number			29d. Date	e signed (Mo	onth, E	ay, Year)	
			+ 1						Λ.	. 3	0		A	1	4	2 - /	77
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Stat		31. Date filed (Mor	nth, Day, Year)	2000	32. Registrar's		re		,								
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DHMH 17 Rev 1/2001

Registrar

09-06438 Brian Price

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 27043

		- For State Registrar				Certifi	icate of	Death				Re	eg. No.	400	2 - 5 - 1 ·	0 4
Physicia	n/	1. Decedent's Name (Firs		t)								Date of Dea Month	Day '	Year	3. Time of Death	
edical Examin		Brian Price										August 17		(D 4)	0858 hrs	
	ı	4a. Facility Name (if not in 2905 Huntingdor		e street and n	umber)			4b. City, To Baltimo		ocation of	Death			nty of Death None	1	
Funeral	╗	Social Security Number	- 1	×	7. Age (In	yrs. last b	oirthday)	If Under	_	If Under		8. Date of Bir	th(MM/DD/YY	YYY) 9. Bir Foreig	thplace (State or	
Director		212 98 2068	E.	M 2 F	29)	Yrs	Months .	Days	Hours	Min.	06/19	/1980	Co	ountry) MD	
any	-	Usual Residence of Dece 10a. State 10b. 0	County	-	10c	. City, To	wn or Locat	ion							10d. Inside City Lir	mits
* .	5	MD	None			Balt	imore								1 X Yes 2	No
Maryland 28a-f sho	Director	10e. Street and Number						10f. Zip 0				1	0g. Citizen of			
3a or		2905 Huntin	gdon A	lvenue				21	211				Unit	ted St	:ates	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int; If item 27 is marked other than "natural", or items 23a or 28a-f she other traumatic event, the Medical Examiner must be notified at once	Funeral	11. Manital Status 1 X Never Married 2	Married	12. Was De Armed F	orces?			is Deceden es, specify				cify Yes or No ican, etc.)		Race - Amer Vhite, etc.	rican Indian, Black,	
ter dez		3 Widowed 4		1 Yes	2 X	No	1	Yes 2	X No	specify:			Speci	ify: Wr	nite	
ours af	a	15. Decedent's Education		or Dates:		ed) 16	a. Deceder						16b. Kind o	f Business/	Industry	$\neg \neg$
6 72 hc	ompleted	Elementary/Secondary	(0-12)	College	(1-4 or 5+)			ost of work	-		se retire	a)				
withir jiene.	E G	12	• 45 d d l = 1 = - 45				Exec	utive			Nome (First Middle	Maiden Suma	staura	int	
21215-0036 Uld be filed within 7. Mental Hygiene. marked other than c event, the Medical	Be	17. Father's Name (First, Terry Lee F)							,	e Gilt		airie)		- 1
Baltimore, MD 21215-0036 semit. Pages I and 2 should be filed within 72 hours afted operatment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" injury or other traumatic event, the Medical Examine	TO E	19a. Informant's Name/R	elationship (T	ype, Print)		-1	19b. Mailin	g Address			-		mber, City or	Town, State	e, Zip Code)	\neg
MD d 2 sho lth and n 27 is aumati		Sherry Lee	Gilta <u>s</u>	*/Mothe	er								PA 1733			
nore, ages 1 an nt of Hea nt: If iter other tra		20a. Method of Disposition 1 Burial 2 Cr		Removal	from State	crer	ce of Dispos matory or ot	her place)		·		Date	1	·	r Town, State	1
Page ment of		4 Donation 5 0	ther Specify										Hanc			_
Baltimore, permit. Pages I ar Department of Hee Important: If ite		21. Signature of Funeral	Service Licer	Isee	0 MC	1044									mily FH Ir y, MD 2104	
Physician	\dashv	23a. Part I. Enter the dise	ease, or comp	lications that	caused the	death. Do									Approximate Inte	erval
Medical		failure. List only one Immediate Cause (Final	e cause on ea	ach line.	nol a										Between Onset Death	and
taminer		or condition resulting in o		Due to (or as			a y cour	ле т	LUZ	Luci	ш					
	<u>_</u>	Sequentially list condition		Due to (or as	a conseque	ence of).								_	+	_
	Examiner	cause. Enter Underlying (Disease or injury that in	Cause												3	
ecuted and transit	Exal	events resulting in death		Due to (or as	a conseque	ence of):										
	ical	XUNPENDED		AMENDED	23a,	27,28	8a-1, ₁	ermE	, g8	96 10	7170)9 T T				
760, ficate be ex g physician the burial	/Medical	IF FEMALE:		23c. If yes	. outcome of		ncy						23d. Da	ate of delive	ry	\neg
687 certific iding p	jan/	23b. Was decedent pregr past 12 months?	ant in the	1 Live	birth gnant at time	o of death	_ =	etal death		Ectopic	pregnan	су	Mon	ith	Day Year	- 1
O. Box 687 at the death certifined by the attending	hysiciar	1 Yes 2 No 9	Unknow		nown	c or death	5 0	ther (Spec	ify)							
O. E at the d by th	۵ ا	Part II. Other significan	conditions	contributing	to death bu	t not resu	ulting in the	underlying	cause gi	ven in Par	rt I.				o the cause of death	
ires that the signed by I be detached	d by	<u> </u>										1Ye			obably 4 Unkno	
ords, w requir	Completed	4											opsy	prior to	autopsy findings avai completion of cause	
Record The language 2	mo												formed?	death?		10
Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to examiner?		Unanital:					- 1/	of Death (par				
Physic al dire	T ₀	1 ✓ Yes 2	No	Hospital:	Inpatient		R/Outpatier		<u> </u>	Other		Home 5	Residence e how injury o		er: Scene	
Division of Vital Records, tal or Attending Physician: The law requir is after death all Director: After this certificate has been seen is director. After this certificate has been seen is director.	on:	27. Manner of Death 1 Natural 5	Pending	(Mor	te of Injury nth, Day,Year)		8b. Time of			es 2 X		unk	e now injury o	Courted		
Attencer death	icati	2 Accident	Investigat	28e. Pl	B/17/(ace of Injury		d 8:4					28f. Location	(Street and N	Jumber or F	Rural Route Number,	City
pital or ours after Dir	Certification:	3 Suicide 6	Could not determine	De	for		at res					BATTET	nore,	Hu	ntington /	Ave
To the Hospital or Attent within 24 hours after death To the Funeral Director:	-	29a. Certifier 1 Cert	fying Physic	ian: To the b	est of my kr	nowledge,	, death occi	urred at the	time, da	te and pla	ce, and	due to the ca	use(s) and ma	anner as sta	ated. the cause(s)	
To T	Medical	29b. Signature and title		and manner	stated.	- 0 /	1			number		-			Month, Day, Year)	
		9/10	2/1	10/	11	4000			O.C.N					t 17, 200		
		30. Name and address of	f person who	completed ca	use of deat	h (Item 2	3a)									
(2)00		Victor Weedn N	ID JD A	ssistant M	_			Penn St	reet, B	altimore	e, MD	21201				
S Regis	tate	31. Date filed (Mon A.D	G'T'9 2	009 32.	Registrar's		13 16	aked							-	
A 210 12				1/		- /*	- 1									

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^D2009 AUGUST 6, **Physician** 5:40A RUDOLPH ADDISON POSEY, SR. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner LAPLATA CHARLES CHARLES COUNTY NURSING & REHAB CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, MAY 10, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours Min 1**X** M 2□ F WASHINGTON, DC 85 10. 1924 218-16-3279 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination once. ¥Yes 2 No Director MD CHARLES INDIAN HEAD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20640 UNITEDSTATES 29 EAST POPLAR LANE Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 MYes 2 No 1943 If Yes, Give Year or Dates: 1945 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No BLACK Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FEDERAL GOVERNMENT HEAVY EQUIPMENT OPERATOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be EARL THOMAS CAROLINE POSEY BRANSOME ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4055 RAVIEN DRIVE, WHITE PLAINS, MD 20695 JUNE T. POSEY/DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State MD VETERANS CEMETERY | 8/13/2009 CHELTENHAM, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signaturg of Fugeral Service Licensee

LYDIA C. THORNION JOHNSON THORNTON FUNERAL HOME, PA 3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) the detached 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 3 Probably 4 Unknown 1 ☐ Yes 2 No icate has been signal page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manger of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOUIS KUAFMAN, M.D., 12070 OLD LINE CENTER, SUITE 207, WALDORF, MD 20602 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 10 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** ROXIE GRINNALDS REW /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Wicomic alisburg If Under 24 Hrs. 8. Date regiona 1 Madical Conta <u>Peninsula</u> Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year) **Funeral** Months Min. 1□M 2**X**F Days 81 218-24-4238 VIRGINIA 03/01/1928 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State iral", or items 23a or 28a-f show Examiner must be notified at 1 XYes 2 □ No **Funeral Director VIRGINIA ACCOMACK** PARKSLEY permit. Pages 1 and 2 should be filed within 72 hours after death with the 1\text{Department of Health and Mental Hygiene.} Important: If item 27 is marked other than "natural", or items 23a or 28a-i any injury or other traumatic event, the Medical Exeminer must be notified anone. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 24319 GERTRUDE ST. 23421 U.S.A. 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 🕱 No Specify. Specify: Completed by 3 ☑ Widowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) PRODUCE **BOOKKEEPER** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ESTELLE LEWIS SOUTHEY C. GRINNALDS ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.O. BOX 1052, PARKSLEY, VA MARK REW / SON 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State PARKSLEY, VIRGINIA 08/08/09 4 ☐ Donation 5 ☐ Other (Specify) LIBERTY CEMETERY 21. Sign were of un and Service Licenses 22. Name and Address of Facility WILLIAMS FUNERAL HOME, 25046 PARKSLEY ROAD, PARKSLEY, VA 2342 T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, soc, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imperiate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Unverlying Cause (Disease or injury that initiated events resulting in death) Last iner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed Exami tran Due to (or as a consequence of): burialphysician s the burial Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Ye ar Day 5 Other (specify) □Yes 2 No Ö been signed by the should be detached 9 Unknown ۵ 23e. Did tobacco use contribute to the cause of death2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy performe PZNo a/Z No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes /2 No 2 ER/Outpatient 3 DOA 1 Npatient Certification: To this 27. Manny of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After t Hospital or Attending 1 Watural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only onel and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

MD

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 🔈 🖺 🖺 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 2009 Year Physician PM August 8:30 Martin Herman Stephan /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Howard 3365 N. Chatham Rd Apt D Ellicott City Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) 09/29/1922 5. Social Security Number 6. Sex **Funeral** Days Hours 1 M 2 ☐ F 216 16 8856 Germany 86 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show am points: If Item 27 is marked other than "hatcal Evanin or items 20 or 28a-f show any injury or other traumatic event, if a Medical Evanin or must be notified at once. 1 ☐ Yes 2 No Director MD Howard Ellicott City 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21042 United States 3365 N. Chatham Rd Apt D Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Items 23 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐ Yes 2 XNo If Yes, Give Year or Dates: 1942-45 Specify: ģ 3 □ Widowed 4 □ Divorced White Be Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Johns Hopkins Elementary/Secondary (0-12) College (1-4or 5+) Applied Physics Lab 5+ Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Herman Frederick Stephan Anna Lena Kittle ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Marsha Cunningham/Daughter 17 Golden Hill Court Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lorraine Park Cemetery8-14-2009 | Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee Them Collin 4112 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final myocardial **Physician** 5 min disease or condition resulting in death) /Medical Due to (or as consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No ned by the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ been signe should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe dialo 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🛛 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 15\(\mathbf{X} \) Residence 6 \(\text{Other} \) Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After 5 ☐ Pending investigation 1 X Natural n 24 hours after death.

e Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of continer August 10, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nd Catmonia mo 21228 N. Pollina JUCCOLLIV 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 11 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2009 1754 August Adrienne Benita Sutton /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Southern Maryland Hospital Clinton If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, **Funeral** Days Hours 1 ☐ M 2 ☐ M Oct. 4, 1970 Wash., DC 38 Director 577 90 0614 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State show ns 23a or 28a-f shormust be notified at 1X Yes 2 No Director Prince George's Fort Washington MD the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with US 12704 Parkton Street 20744 Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items; eny injury or other traumatic event, the Medical Experiment once. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 ☐ XHo Specify. ğ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Administrator</u> APPTIS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lorie Griffin Christopher Sutton ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20748 3015 Brinkley Station Dr. Temple Hills, MD 19a. Informant's Name/Relationship (Type. Print) Loleatte Jones/sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-14-09 Clinton, MD Resurrection Cem 21. Signature of Funeral Service License 902 22. Name and Address of Facility BRISCOE-TONIC FUNERAL HOME 2294 Old Washington Rd Waldorf, MD20601 23a. Pa/11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, strock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** (1170 /Medical Due to (or as a consequence of): **Examiner** Hoult Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physiclen: The law requires that the death certificate be executed Warron 47 attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 □Yes 2 XNo 5 Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 181096 certificate has been s rector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed?
1 □ Yes 2 ☑ No 1 ☐Yes 2 ☐ No this certific al director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ri⊠Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Scritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0028035 Pis cataway 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BHS/RMCHMAD F. KOLIA IN.D. 9132 32. Registrar's Signature 31. Date filed (Month, Day, Year) State parke Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per State 88 Maryland 9 Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 0743 M 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Walter 2009 Emory Sweeney, Jr. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 309134 Sequity Number Days 89 214 16 6370 July 3, 1920 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 □ No MD Washington Hagerstown 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 348 Devonshire Road 21740 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☑Yes 2 ☐ No Black, White, etc. 1 ☑ Yes 2 ☐
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Boilermaker Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Emory Sweeney, Sr. Agnes Elower 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Freda M. Sweeney/Wife 348 Devonshire Road, Hagerstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 8/18/2009 Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel Mark 1601 Pennsylvania Ave., Hagerstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Arterioschrotic Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or so a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical **Examiner** Hospital or Attending Physician: The law requires that the death certificate be executed

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at

Health and Mental Hygiene. em 27 is marked other than ther traumatic event, the M

permit. Pages 1 and :
Department of Health
Important: If item 27
any injury or other tr.
once.

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examine burial-tran Physician/Medical attending p for use as t signed by the a ģ Completed page 2 s Be after death.

Director: After this ce d in by the funeral direc Medical Certification: To

											24a. Was an autopsy performed?	24b. Were autopsy findings ava prior to completion of caus death? 1 ☐ Yes 2 ☐ No	
		red to medical						26.	Place of Dea	th (Check only one)		
	examener? ☑Yes 2☐	No	Hospital	: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3 🖳	БОА	Other: 4	☐ Nursing H	lome	5 Residence 6	Other (Specify)	
27. Manner of Deat 1	5 Pending investigation		Date of Injury (Month, Day, Year)	28b. Time of Injury	М		Injury at Work? 1 □ Yes	2 🗆 No	28	d. Describe how injury o	occurred		
		6 Could not be determined	28e.	Place of Injury - At h building, etc. <i>(Speci</i>	ome, farm, stree	et, facto	ory, off	ice		28	f. Location (Street and I City or Town, State)	Number or Rural Route Number	r,
29a	Certifier (Check only		nlner: Or								d due to the cause(s) at the time, date end pl	and manner as stated.	

Division of Vital Records, P.O. Box 68760,

29b. Signature and title of certifie

29d. Date signed (Month, Day, Year)

cause of death (Item 23a) (Type, Print) MID

24 2000

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

24 hours at Funeral D within 24 hor To the Fune completely fi

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 11:15 PM **Physician** 5, 2009 August Clarence W. Taylor /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Wicomico Salisbury Atria Assisted Living If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** 11/30/1914 Days Hours Min. 1**X** M 2 □ F Maryland 94 213-01-7512 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Wedical Experience, ust by redilled at 1 ☐ Yes 2 🐪 No Director Salisbury Maryland | Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21801 23a 7910 White Lowe Rd. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 72 hours after 1 ☐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White altimore, Maryland 21215-0036 1 ☐Yes 2 No Specify þ 3 X Widowed 4 Divorced 2 should be filed within 72 hours and Mental Hygiene. Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Maryland Highway Elementary/Secondary (0-12) College (1-4or 5+) Administration Maintanence 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Ellen Hitch Charles P. Taylor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traun 27606 Ocean Gateway Hebron, Maryland 21830 Albert Murray/friend 20b. Place of Disposition (Name of cemetery, crematory or other place)

Bates Memorial 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burlal 2 ☐ Cremation 3 ☐ Removal from State 08/10/2009 Snow Hill, Maryland 4 ☐ Ponation 5 ☐ Other (Specify) Methodist Cemetery Furieral Service License HOLLOWAY Funeral Home P.A. 501 Snow Hill Rd. Salisbury, Maryland 21804 Party . Enter the disease, or complications that cause shock, or heart failure. List only one cause or each lin Approximate Interval Between Onset and Death e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, fastatic prostate caused Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) ed by the a Division of Vital Records, P.O. 9 Unknown After this certificate has been signed by funeral director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 Z No 1 ☐Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Pother (Specify) AGG 164 Artist 1 Yes 2 1No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D32014 mally your 60 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 106 WILLANDSF- 504 15 SUITIONAL MD 21804 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

		1	For State Registrar	State of Ma	aryland		rtment of H tificate of L		-	Reg. No.	UUS	2/000
Dh	ysicia		1. Decedent's Name (First, Middle			, .	/1 /- T	Mobin	2. Date of De Month	ath Day	Year	3. Time of Death
	ysıcıa Medic	al -	Oliver Lee Tob			bin a		Location of Death	Aug. 1	.8,	2009 County of Death	8:50 A M
Ex	amin	er	4a. Facility Name (If not institution Forest Hill He	-		er		st Hill		40.	Harfor	
Fun	eral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. lasi		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ay, Year)		nplace (State or Foreign
Dire			185-28-6191	1 X M 2□F	73	Yrs.	Months Days		Mar. 25	, 19	36	PA
and	#	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Loc	cation					10d. Inside City Limits
Maryl Ff sho	fleds	tor	PA Yo	rk			Fawn G	rove				1 XYes 2 No
th the	a not	Director	10e. Street and Number	-			10f. Zip Code	15001		_	zen of What Co	untry?
ath wi	ustb	rall	488 N. Marke			T.0.1	1	17321	anife Van or Ne		.S.A.	rican Indian
5-UUSD 72 hours after death with the Maryland natural", or items 23a or 28a-f show	event, the Medical Exacilmental bandiffied at	by Funeral	11. Marital Status 1 □ Never Married 2 Marr 3 □ Widowed 4 □ Divorced	If Yes Give			vas Decedent of H f Yes, specify Cuba I □Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)		Black, White	
13-0036 72 hours aft "natural", or	calE	ted	15. Deceden	t's Education	16	16a. Deced	lent's Usual Occup	ation during most of work	rina	16b. Kii	nd of Business/I	Industry
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nd ZIZI e filed within af Hygiene.	nt, the	S	17. Father's Name (First, Middle,	l act)			Chemist	18. Mother's Nam	e (First, Middle			11
Yland yland buld be file Mentaf H arked oth	c evel	9 Be	Oliver L. To					Lillia	_	_		
- ~ D F	umati	ဍ	19a. Informant's Name/Relations	hip (Type. Print)		19b. Mailin	g Address (Street	and Number or Ru	ral Route Numb	er, City o	r Town, State, Z	Zip Code)
≥ ₹ 5	i t		Charmaine R.	Tobin/Wif	- 1			et St.,				
IMOFe, Pages 1 au nent of He int: If item	or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 ☑ Removal from State	20b. Plac cerr	e of Dispo etery, cren	sition (Name of natory or other place DIT	Aug.			cation - City or	
Saltimor permit. Pages Department of mportant: If it	njury		4 □ Donation 5 □ Other (S	ipecify)	Ceme	etery		, 200			wood,	tuary, Inc.
Baltimor permit. Pages Department of Important: If it	any l		21. Signature of uneral service	Licensee		19) S. Mai	in St.,	Stewa:	rtst	own, P	A 17363
			23a. Part 1. Enter the disease, or shock, or heart failure. List	r complications that cause	d the death.							Approximate Interval Between
Physic	cian		Immediate Cause (Final disease or condition	cv								Onset and Death
/Med Exam			resulting in death)	Due to (or as	a conseque	nce of):						
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₽	for use as	/Me	IF FEMALE:	23c. If yes, outcome	e of pregnanc	:y					23d. Date of de	livery
O. BOX the death cer	ched for u	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown			☐ Ectopic pregnanc ☐ Other (specify) _	cy			Month	Day Year
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VITAL KE iclan: The lav certificate has	r, page								1 □ Yes	2 No	1 ☐ Yes	2 No
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9 Physer this	funeral director, p	n:To	27. Manner of Death	28a. Date of In	jury 2	8b. Time o Injury		ry at	28d. Describe			scily)
ion ath.	ne fun	atio	Z LI Accident	igation	ay, rear/	injui y		Yes 2 □No				
DIVISION OF VITA II or Attending Physician: after death. Director: After this certific	filled in by the	Certification: To	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deterr	Zoe, Flace of I	ijury - At hom tc. <i>(Specify)</i>	e, farm, str	reet, factory, office		28f. Location City or To	(Street ar own, State	nd Number or R e)	ural Route Number,
Hospita 24 hours	etely filled	edical Co	29a. Certifier (Check only one) Certifyi 2 Medica	ng Physiclan: To the bes Examiner: On the basis and manner s	of examination	edge, deat on and/or in	th occurred at the to	ime, date and place opinion, death occu	Le, and due to thurred at the time	e cause(s e, date an	s) and manner a d place, and du	e to the cause(s)
To the	compl	Me	29b. Signature and title of certific	er		-	29c. Licens	se number		29d. Da	te signed (Mon	th, Day, Year)
	-		Dank 5				023	2295		an	gent 13	2005
			30. Name and address of persor DR DAVID DU					AIR, MD	21014			,
	Sta	ite	31. Date filed (Month, Day, Year									
R	egistr	ar	AUG 24 2	009 Sentin	1 19.	1 par	Ke					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month AUGUS DONALD NOAH WILSON **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Doctor's Community Hospital Lanham Hours Min. 8. Date of Birth (Month, Day, July 30, Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Numbe Sex 1XXM 2□ F 7. Age (In yrs. last birthday) **Funeral** Days 1929 Florida 80 263-42-2597 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Exprinter must be rediffed and once. MXWes 2 □ No Maryland Prince George's Bowie Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20715 U.S.A. 12817 Beaverdale Lane Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1XXes 2 □ No USAF
If Yes, Give
Year or Dates:48-1952 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 White 1 ☐ Yes XX No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)

Head of Leased Wire Department of Elementary/Secondary (0-12) College (1-4or 5+) Agriculture -12-Agriculture Marketing News 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maggie Birchfeld Clifford Wilson ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12817 Beaverdale Lane, Bowie, Maryland 20715 Leona T. Wilson/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other pla Maryland Veterans 20c. Location - City or Town, State Date 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 8/10/2009 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 21. Signature of Funeral Service 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Circholi 11 KNOUN disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hyper Intensium Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed poucy lopesid burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical liter the attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Dav in the past 12 months?
1 □ Yes 2 □ No Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 4 Unknown icate has been siç ; page 2 should b Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 (1) Inpatient Certification: To 1 Yes 2 4No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely (Check only one) and manner stated within 2 29b. Signature and title of certifier CHAMPALOUX 29d. Date signed (Month, Day, Year) 29c. License number 3109 D20905 30. Name and address of person who completed cause of death (Item 23a) (Tyrie, Print) Champaloux Gerard Gallont FUX Laine Bour AUG 07 32. Redistrar's Signature 31. Date filed (Month, Day, State Dark

DHMH 17 Rev 1/2001

Registrar

		-	For State of N State Aregistrar		ertificate of Dea Partificate of Dea		lygiene Reg. No. 20	09	27052
			Decedent's Name (First, Middle, Last)			2. Date of Month	Death Day	Year	3. Time of Death
	Physicia /Medic	_	Louise E. Weat	herington		Aug.	5, 200		6:47 P M
Ĉ.	Examin		4a. Facility Name (If not institution, give street and number		4b. City, Town, or Loc	ation of Death	4c. County		
4	2,0		C-vista Medical Center		LaPlata	Jnder 24 Hrs. 8. Date of		rles	lace (State or Foreign
ď.	Funeral Director		5. Social Security Number 6. Sex 1 M 2 T F 7. A	Age (In yrs. last birthday Yrs.		ours Min. (Month, Sept.	^{Day, Year)} 25,1925	Coun	
	TO		Usual Residence of Decedent					1	0d. Inside City Limits
	arylan show d at	7	10a. State 10b. County Maryland Charles	10c. City, Town or L	dorf				1 ☐ Yes 27 No
	the M	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of	What Coun	
	3a or		12822 Twin Oak Drive		20601		USA		
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ant, the Medical Examiner must be notified at	Funeral	11. Marital Status 12. Was Deceder Armed Force		B. Was Decedent of Hispa If Yes, specify Cuban, M	nic Origin? (Specify Yes or lexican, Puerto Rican, etc.)	No- 14. Rac Blac	ce - Americ ck, White,	
36	irs afte ir', or I xamir		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give 2 ☐ Year or Date:	K NO	1 ☐ Yes 2XXXVo Si	pecify:	Specif	y:	White
21215-0036	'2 hou natura ical E	Completed by	15. Decedent's Education (Specify only highest grade completed)	16a. Dec	edent's Usual Occupation	n na most of working	16b. Kind of B	usiness/In	dustry
21	ithin 7 ne. "ran "r	mple	Elementary/Secondary (0-12) College (1-4c	or 5+)	ve kind of work done during DO NOT use retired) memaker	3	Dor	nesti	С
2	iled w Hygier ther th		10 17. Father's Name (First, Middle, Last)	ПО		Mother's Name (First, Mic			
and	d be f ental h ked ol c eve	To Be	Joseph Clyde Horton	n		Lula I	E. O'Nea	al	
Maryland	shou and M s mar	F	19a. Informant's Name/Relationship (Type. Print)			Number or Rural Route Nu			
	and 2 ealth n 27 I		Jeffrey Rinkes-Grandson	n 32		Lane, Prince	Frederical 20c. Location		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1	cemetery, ci	rematory or other place) eltehnham	Aug.17,200			, Maryland
Balt	permit. Departr Importa any Inji		21. Signature of Funeral Service Licensee	M01533	22. Name and Address of 6633 01d A	Lee Fullity Lee Fullexandria Fe	uneral Ho rry Rd, C	me, I linto	nc. n,MD 20735
*	Physician /Medical Examiner	Examiner	Coquantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	as a consequence of):	SOTTE O	CAR) 10CA	CEVAN I	0(15	Approximate In rval Between and Death
x 68760,	certificate be executed iding physician and ise as the burial-transit	dical	IF FEMALE: 23c. If yes, outco				23d. D.	ate of deliv	ery
P.O. Box	that the death certifii ed by the attending I detached for use as	Physician/Me	in the past 12 months?	t at time of death	3 □Ectopic pregnancy 5 □ Other <i>(specify)</i>		M	onth	Day Year
	The law requires that the death certifice has been signed by the attending lage 2 should be detached for use as	ed by Pl	Part II. Other significant conditions contributing to deat	h but not resulting in the	e underlying cause given in	TO KILL	Did tobacco use cor 1 ☐ Yes 2 X No		the cause of death? bably 4 Unknown
Division or Vital Records,	The law re ate has ber page 2 sho	Completed by				i	autopsy performed?		opsy findings available ompletion of cause of 2□ No
/ita	ysician: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?			6. Place of Death (Check of	nly one)		
Or.	Physician: this certific ral director,	은	1			4 Nursing Home 5 28d Desc	Residence 6 00		ify)
on	Attending r death. ector: After by the funer	tion		Day Year) Injur	y Work?	s 2 □ No			
)ivisi	l or Atter after deal Director I in by the	Certification:	3 Suicide 6 Could not be 28e. Place of	f injury - At home, farm, , etc. (Specify)	street, factory, office	28f. Locati City o	ion (Street and Num r Town, State)	nber or Rui	ral Route Number,
	Hospita 4 hours Funeral ely filled	Medical Ce	29a. Certifier 1 Certifying Physician: To the bas one) 2 Medical Examiner: On the bas and manne	is of examination and/or	eath occurred at the time, r investigation, in my opin	date and place, and due to ion, death occurred at the	o the cause(s) and r time, date and place	nanner as e, and due	stated. to the cause(s)
	To the I within 24 To the I complet	Me	29b. Signature and title of certifier		29c. License n	umber	29d. Date sign	ed (Month	, Day, Year)
			100		D18	542	AUG.	10	12007
	JA5		30. Name/and address of person who completed cause	of death (Item 23a) (Typ	pe, Print)	S 95 RE CENTER	WALDE	NF A	ld. 2060
	St. Regist	ate rar	31. Date filed (Month, Day, Year) 32. Per AUG 10 2009	gistrar's Signature	parker				

09-06355 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Courtney Weschler State of Maryland / Department of Health and Mental Hygiene 2009 1- For State Certificate of Death Rea. No Registrar 2. Date of Death Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ August 13, 2009 1539 hrs Medical Examiner Courtney Weschler 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Charles Waldorf 3044 October Place If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) **Funeral** Min. WashingtonDC Months Days Hours March 11,1977 Director 212-11-4451 32 M 2 X F Yrs Usual Residence of Decedent 10a. State 10b. County Oc. City, Town or Location 10d. Inside City Limits narked other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at once, Waldorf Yes 2 X No MD Charles permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 3044 October Place 20602 USA , Apt. G Funeral 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc Armed Forces? 1 X Never Married 2 Married Yes White Widowed Divorced Yes, Give Year Yes 2X No specify. Specify þ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 Retail Pharmacy Inventory 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Jo Kohler William Paul Weschler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 38020 Indian Creek Dr. Charlotte Hall,MD 20622 William Weschler/Father 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, 1 X Burial 2 Cremation 3 8/18/09 Waldorf, Maryland Trinity Memorial Gar. Donation 5 Other Specify: 21. Signature of Funeral S dic Licensee ÄREHART-ECHOLS FUNERAL HOME, P.A. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one rause on each line. Between Onset and /Medical Death a. Atherosclerotic cardiovascular disease Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Division of Vital Records, P.O. Box 68760, tall or Attending Physician: The law requires that the death certificate be executed Physician/Medical 23a,PII,27,perME, g894 8/31/09 TT X UNPENDED attending physician or use as the burial 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Live birth has been signed by the attending 2 should be detached for use as t Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 🗸 Unknown Unknown Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. ρ 1 Yes 2 No 3 Probably 4 V Unknown Seizure disorder Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy this certificate has performed? death? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Other₄ examiner? Hospital: 1 Nursing Home 5 Residence 6 ✔ Other: Scene DOA Inpatient ER/Outpatient 3 1 🗸 Yes 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification:

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: completely filled in by the

1 X Natural

4

Medical

State Registrar

Accident

Suicide

Homicide

29b. Signature and title of certifier

Pending

Could not be

30. Name and address of person who completed cause of death (Item 23a)

determined

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ana Rubio MD. 31. Date filed (Month Deg Year) 8 2009 Régistrar's Signature

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

O.C.M.E

Yes 2 No

28f. Location (Street and Number or Rural Route Number, City

August 14, 2009

29d. Date signed (Month, Day, Year)

for State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 08 **Physician** ELIZABETH 2009 JANE WILLIAMS 16 1709 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 M 2 X F 89 APR 28, 1920 MARYLAND Director 564-26-5671 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show traumatic event, the Medical Examiner must be notified at Director Yes 2 □ No MDALLEGANY CUMBERLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 21502 U.S.A. 750 WASHINGTON STREET or items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) MODEL - CONOVER MODELING MODELING/ADVERTISING 1 and 2 should be filed wi Health and Mental Hygier em 27 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DR. WILLIAM FREDERICK WILLIAMS VIRGINIA ELLEN (MANN) WILLIAMS ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is a any Injury or other traus once. 33908 FT. MYERS, FLEVELYN STALLINGS SISTER 9150 CHERRY HILL CT. 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State HILLCREST MEM PARK AUG 21 09 CUMBERLAND, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HAFER FUNERAL SERVICE, PA 21. Signature of Funeral Service Licenses 1302 NATIONAL HWY., LAVALE, MD 21502 23a. Pa 11. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. Let only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final Physician Chronic RAIS evere disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ≥ hy pertension 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 roniz autopsy performe 1 ☐ Yes 2 ☐ No **Division of Vital** 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hours after 4 ☐ Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the F 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature

State Registrar 30. Name and address

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

pleted cause of death (Item 23a) (Type, Print)

DO018216

200 settin Dr. Camberland Mo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		For State of Maryland / Depart	tment of Health and N ificate of Death		iene eg. No. 11 (11 (11 (11 (11 (11 (11 (11 (11 (11	We may be time to			
الناوا		Decedent's Name (First, Middle, Last)		2. Date of Death	h LJJ	3. Time of Death			
Physicia /Medica		Esther Marie Altevogt		August 2	20,2009 Year	5:00A M			
Examine			4b. City, Town, or Location of Death		4c. County of Death	1			
		Overlea Health & Rehab 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Overlea If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Baltimo				
Funeral Director			Months Days Hours Min.	(Month, Day,	Year) Cou	iplace (State or Foreign intry)			
D		Usual Residence of Decedent		01-14-1	920	KY			
arytan show	٠	10a. State 10b. County 10c. City, Town or Locat	tion			10d. Inside City Limits			
he Ma 8a-f	Director	MD Harford Fallst		1		1 ☐ Yes 2€ No			
with t	ă	10e. Street and Number 2104 Oaklyn Dr	10f. Zip Code	10	og. Citizen of What Cou	intry?			
ns 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Wa	21047 as Decedent of Hispanic Origin? (Sp	ecify Yes or No-	USA 14. Race - Amer	ican Indian,			
330 Sur s s s s s s s s s s s s s s s s s s s	2	1 Never Married 2 Married 1 Yes 2 TNO	′es, specify Cuban', Mexicanĭ, Puèric]Yes 2 <mark>ᅑ</mark> No <i>Specify:</i>	Rićan, etc.)	Black, White				
5-0 72 ho 72 ho dical	Completed	15. Decedent's Education 16a. Deceder (Specify only highest grade completed) (Give kir.	nt's Usual Occupation and of work done during most of work NOT use retired)	ing I	16b. Kind of Business/I	ndustry			
within within than "	E E	Elementary/Secondary (0-12) College (1-4or 5+) Sales	·		Damat 1				
filled v Hygie int, th	္ဌ	17. Father's Name (First, Middle, Last)		e (First, Middle, N	Retail				
ld be ental ked o	lo Be	Lewis Conway		Mulkey	,				
ary shou and M s mar	-1		Address (Street and Number or Rui		City or Town, State, Z	ip Code)			
and 2 and 2 ealth in 27 I		Carolyn Jo McKenny (Daughter) 2104 0	aklyn Dr Fallst	on, MD 2	1047				
altimore, mit. Pages 1 ar spartment of Her portant: if Item y Injury or othe		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State	ion (Name of tory or other place)		20c. Location - City or 1	Town, State			
Itim trimen rtant:	-	4□Donation 5□Other(Specify) Highview N			allston, MI				
Ba permi Depa Impo any li		Dans Trode Inc	Name and Address of Facility Sch 610 W. MacPhail	Rd BelA	ir, MD 210	e of BelAir 14			
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	the mode of dying, each as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death			
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a zulls	tage					
Examiner	De color as a consequence of): De cubiti Ulcer								
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	100011						
nd transit	Examiner	that initiated events	tennor	-					
		resulting in death) Last Due to (or as a country quarter of):							
ficate physics the sthe	edical	d							
Hecords, P.O. Box 6 The law requires that the death certifite has been signed by the attending lage 2 should be detached for use as	Pnysician/in	IF FEMALE: 23c. If yes, outcome pf pregnancy			23d. Date of deli	very			
b deat he atte ed for	Sicia	1 Yes 2 No 4 Pregnant at time of death 5 O	ctopic pregnancy Other (specify)		Month	Day Year			
s that the de ned by the a	y y	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the under	advisa source since in Book I	00a Did tab		Ab			
Hecords, he law requires the has been signe age 2 should be d	6	art ii. Other significant continuous contributing to death out not resulting in the under	enying cause given in Part I.	23e. Did tob	eacco use contribute to es 2 □ No 3 □ Pro				
cords, w requires to be signer should be) ale								
VITAI REC sician: The law certificate has t irector, page 2 s	Completed			24a. Was ar autops perforn	y prior to o ned? death?	topsy findings available ompletion of cause of			
		25. Was case referred to medical	26 Place of Deat	1 Yes 2 h (Check only one	Yes 1 ☐ Yes	2 No			
r VI	o i	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	Other: 1		nce 6 □Other (Spec	eify)			
On Or ding Phy h. After this funeral d		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work?	28d. Describe ho					
ttendi leath. tor: A the fu		Accident investigation	M 1 Yes 2 No						
DIVISION (Ital or Attending F Its after death. Tal Director: After Ied in by the funer.		4 Homicide determined determined 28e. Place of injury - At home, farm, street building, etc. (Specify)	t, ractory, office	28t. Location (Str City or Town	reet and Number or Ru , State)	ral Route Number,			
		29a. Certifier 12 Certifying Physician: To the best of my knowledge, death or	ccurred at the time, date and place,	and due to the ca	ause(s) and manner as	stated.			
thin 24 hour the Fune ompletely fi		(Check only one) 2 ☐ Medical ExamIner: On the basis of examination and/or investand manner stated.	stigation, in my opinion, death occur	red at the time, da	ate and place, and due	to the cause(s)			
To t To t	2	29b. Signature and title of certifier	29c. License number	7 / 29	9d. Date signed (Month	n, Day, Year)			
1		· run my	100351		0-21-	2009			
4		30. Name and address of person who completed cause of death (Item 23a) (Type, Prince 1) 1. Date filed (Month, Day, Year) 32. Registrar's Signature 4 AUG 25 2009	Raven Blv.	d 1/2	Saltimor	2009			
State Registra	r	AUG 25 2009 Seven S. Sanker							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20° 200° August 6:20 A M Chester Edward Akers Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Center Towson 8. Date of Birth (Month, Day, Year, July 26 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 👿 M 2 🗆 F Months Days Hours Maryland 50 **Director** 220-68-4862 1959 Usual Residence of Decedent or 28a-f shov notified at 10d, Inside City Limits 10a, State 10c. City, Town or Location Director MD Baltimore 1 Yes 2 X No Essex 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ò "natural", or items 23a o Funeral 21221 USA 1022 N. Marlyn Avenue within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc Armed Forces þ 1 Never Married 2 Married ☐ Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 ▼Widowed 4 □ Divorced Completed Year or Dates er than "natur , the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the May injury or other traumatic event the May injury or other trauma Elementary/Seconday (0-12) Truck Driver Commercial Trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Unk. Chester Edward Akers, Sr. Pear1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1022 N. Marlyn Avenue Essex, MD Kim K. Kelley, Step-daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc. 08/21/09 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Records, P.O. Box 687 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Day 1 Yes 2 9 Unknown ned by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sign COCAME 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law is within 24 hours after death.

To the Funeral Director: After this certificate has be completed filled in by the funeral director, page 2 s autopsy perform 1 🗌 Yes 2 🗌 No 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence မ 6 Nother (Specify) WSPLU 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

© Medical Examiner: On the basis of examination and/or investigation is my artifact in the cause of the cause Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

State Registrar

31. Date filed (Month, Day,

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

15+ 20 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death 3:00 AM AUGUST MARIA GUADAL APARICIO ALCOCER 2009 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death MONTGOMERY NATIONAL INSTITUTES OF HEALTH BETHESDA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) 6. Sex 8. Date of Birth Months Days Hours 1 □ M 2 🕱 F 48 12/12/1960 Unk. Mexico Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1XIYes 2□No Travis Austin 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Mexico 1401 Rundberg Ln. 78753 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1⊠Yes 2∐No Specify: Mexican 3 Widowed 4 Divorced Hispanic 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) General De Seguros Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Petra Alcocer Gonzalez Antonio Aparicio Castaneda 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Antonio Fernandez/ Husband 1401 Rundberg Ln. Apt. #95 Austin TX 78753 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. 8/25/2009 | Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall's Funeral Home M00977 4217 9th St NW Washington DC 20011 23a. Park Erner the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPTIC disease or condition resulting in death) HOURS Due to (or as a consequence of): DAYS NEUTROPENIA Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last YEARS MYELDID LEUKEMIA CHRONIC Due to (or as a consequence of) 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 🗷 No 2 🔲 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital:

Physician /Medical Examiner

Physician

/Medical

Director

by Funeral

Completed

Be

10a. State

TX

Examiner

Funeral

Director

show

in than "natural", or items 23a or 28a-f show the Medical Experience must be notified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any Injury or other traumatic event, the Magnet Pines.

filed within 72 hours after death

altimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records,

Hospital or Attending

Examiner burial-transi attending physician for use as the burial Physician/Medical signed by the a þ Completed certificate Be Certification: To After this thin 24 hours are: o the Funeral Director: Af

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? □Yes 2 No

examiner? 1 Yes 2 No 27. Manner of Death

5 Pending

investigation

6 ☐ Could not be

1 🔀 Natural

2 Accident

3 Suicide

(Check only one)

1 🔀 Inpatient 28a. Date of Injury (Month, Day, Year)

2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier Sunitaria Voor, Clinical Jellow, Hematology Branch, NHLBI

29c. License number D64820 29d. Date signed (Month, Day, Year) 8-22-2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUMITHIRA VASU

10 CENTER DRIVE, BETHESDA, MARYLAND 20892

State Registrar

Medical

31. Date filed (Month, Day, Year) AUG 25



DHMH 17 Rev 1/2001

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. L. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** AUQUST 08:15PM Carolyn Adams Henrietta /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Town, or Location of Death Examiner 1 timore Hanes N/AHOSPI Tal If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1 ☐ M 2 🔀 F 216-36-4183 1939 Maryland 30, Jan Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1X Yes 2 □ No Marvland Baltimore City Baltimore 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code United States 21230 Funeral 1820 Spence Court Apt.#112 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify. 2 SpecifyWhite 3 ☐ Widowed 4 💆 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louis E. Fink Margaret Agnes Perry ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2008 McHenry Street, Baltimore, Maryland 21223 <u>Laura C. Malinows</u>ki/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Auguste 24, 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 2009 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. Baltimore, Maryland 22. Name and Address of Facility Cremation Society of Maryland, Inc. 21. Signature of Funeral Service Licensee Amanda Heaston 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Metabolic 101000S if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Aoitic evere) Due to (or as a consequence of): Failure - Acute gestive Physician/Medical IF FEMALE yes, outcome of pregnancy ☐ Live birth 2☐ Fetal death ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 ncocca bacteremia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Arte OVO 1 Yes 2 No 1017 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 patient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

and Division of Vital Records, P.O. Box 68760, Addms, Henrietta

ed by the attending physician detached for use as the buria vis certificate has been signed by director, page 2 should be detact this certificate Hospital or Attending Physician: '24 hours after death.
Funeral Director: After this certifica funeral completely filled in by the 24 hours a To the Within 2

Funeral

Director

show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Exact in a roust by motified at once.

Physician

/Medical

Examiner

burial-tran

Baltimore, Maryland 21215-0036

Registrar

Medical

31. Date filed (Month, Day, Year) State

29a. Certifier

(Check only one)

29b. Signature and the of of

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) torales MM

and manner stated.

on Avenue.

to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

P23746

29c. License number

29d. Date signed (Month, Day, Year)

Baltimore, MD 21229

August 22, 2009

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 08-20-2009 Physician 630 P M George M. Blunt /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford 1292 Pearson Place Belcamp | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 04-17-19 20 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F MD 89 Director 213-03-1306 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ed other than "natural", or items 23a or 28a-f show event, the "Modes! Exeminer must be rediffed at 1 □Yes 2X No Director Belcamp MD Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number within 72 hours after death with USA 21017 1292 Pearson Place Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify Specify: White þ 3 X Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental College (1-4or 5+) Aerospace defense Photo Tech 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Augusta Litzow John Blunt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1292 Pearson Place Belcamo, MD 21017 Joan L. Turner (Daughter) 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08-25-2009 Baltimore, MD Gardens of Faith 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee Berai Inc 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 2008 End Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine 2004 The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Vear 5 Other (specify) signed by the a Tyes 2 No. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ ypen tension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l page 2 s autopsy performed certificate 1 □Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ Medical Exampler On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) nd manner stated. 29b. Signature and title of certifier 5 N 55846 an 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Beloir Rd. and man, up 02 CISON 31. Date filed (Month, Day, Year) 82. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Lena Branner Bridgett 24, 8:07 August 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Center Timonium Baltimore If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year)
Aug. 20, 1924 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F 226 30 7700 85 Yrs Director Virginia Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r 28a-f shov 1 ☐ Yes 2 No Maryland Baltimore Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number If item 27 is marked other than "natural", or items 23a or or other traumatic event, inc Medical Examiner must be a 7901 Wynbrook Rd. 21224 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: White Maryland 21215-0036 1 ☐Yes 2 No If Yes, Give Year or Dates Specify 2 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LPN Nurse Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George H. Olinger Maggie Susan Branner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles R. Bridgett (Son) 7901 Wynbrook Rd. Baltimore, Maryland 21224 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 8/28/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Bruzdziński Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 Bruzdzinski Funeral Home P.A 1407 Old Eastern Avenue Esse:

23a. April: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, brock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has 1 autopsy 1 □Yes 2**X** No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1**X** Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral D Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

One Nurse Practitionermer stated. 29a. Certifier 29c. License number 29b. Signature and title g 29d. Date signed (Month, Day, Year) 009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. JACKIE JONES, CRNP TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature

Registrar DHMH 17 Rev 1/2001

State

AUG 25

10 arks

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Pay 2009 Year Frances Mary Berk August 24 5:40 Α Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center for Hospice Towson Baltimore . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Days Hours Min. 0270671915 215-34-6103 Virginia Director 94 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits Examiner must be notified at 10c. City. Town or Location Director Maryland Baltimore 1 Yes 2XXNo Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral 23a 8620 Kelso Drive, Apt. "D" 302 21221 U.S.A. or items death 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian Yes, specify Cuban, Mexican, Puerto Rican. etc. Armed Forces?
1 ☐ Yes 2X No Black, White, etc. þ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: White "natural", 3 X Widowed 4 Divorced Completed Year or Dates Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than College (1-4 or 5+) 6 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George W. Danson Annie Savin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Anne Ringsdorf (Daughter) 239 Southeastern Court, Baltimore, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Zion U.C.C. Cemetery | 08/27/2009 | Baltimore, maryland 21. Signature of Euneral Service Licensee 22. Name and Address of Facility nski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shook, or heart failure. List only one cause on each line.

Immediate Cause (Final omplications of Demutia Physician/ diser e or condition resulting in death) Larg Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) Month Year Pregnant at time of death ed by the a a Unknown g Unknown Division of Vital Records, P.O. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ The law requires 1 Tes 2 No 3 Probably 4 Unknown cate has been signated bage 2 should be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? certificate 1 ☐ Yes 2 ☐ No Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 **X** No Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Gilchn S ည 1 Inpatient 2 ER/Outpatient 3 DQA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of within 24 hours after death.

To the Funeral Director: After t
completed filled in by the funera Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check To the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) R149 194 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 54. Towson Marian Charles MD Grant 0701 21204 North 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 2⁰2, 200⁹ **Physician** 8:57 PMLinda Joyce Beckner /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 4 Branch Street Essex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Months Days Hours 1 M 200 58 Yrs. 08/22/1951 Maryland 216-62-5646 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Navideal Evantian or must be multified at 1 ☐ Yes 🏋 No Director Maryland Baltimore Essex 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 4 Branch Street 21221 Funeral within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※XXNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 XX arried Baltimore, Maryland 21215-0036 1 □Yes 2 XXXIII Specify. Specify. 2 White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) s 1 and 2 should be filed within of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Tavern Bar Maid 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joyce Chandler Robert Greenfielder ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4 Branch Street, Baltimore, Maryland 21221 Russell Beckner (Husband) permit. Pages 1 a
Department of Hes
Important: If item
any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ACremation 3 ☐ Removal from State Bayview Crematory, Ind. 08/24/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility
Bruzdzinski Funeral Home, 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Lung **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed and burial-tra Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760 ned by the attending physician detached for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown cate has been signed by page 2 should be detacl The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 🛣 No 1 🔲 Inpatient 2 ER/Outpatient 3 DCA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Magner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 □ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title Acertifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

egistrar's Signature

Squire Dr. Baldinere MO ZIZ37

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 7.21 5 TIN tznev 22 09 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner UMM Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1**√** M 2□ F 218 56 1174 57 Maryland 09/02/1951 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" --- any injury or other traumatic exercises. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 ☐ Yes 2 ☐ No Director Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21224 813 Bouldin Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ⑤ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 No Specify: White Specify. Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bank Maintenance Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alice Ridgel Butzner Sr. George ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7815 St. Patricia Lane Dundalk Maryland 21222 George Butzner (son) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Memorial Gardens 8/25/09 Harford Co., Maryland 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home PA Funer | Servic Licensee 1407 Old Eastern Avenue Essex MAryland 21221 W complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Pert 1 Enter the disease, or sloc or heart failure. List Onset and Death Immediate ause (Final disease de ndition resulting in death) 101 SMALL CEL **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner requires that the death certificate be executed that initiated events resulting in death) Last burial-tra Due to (or as a consequence of): physician a O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death nse 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) ed by the a □Yes 2□No a I I Inknown 9 Unknown signed by t ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has b e 2 sl autopsy performed? 1 ☐ Yes 2 ☑ No page 1 ☐Yes 2 ☐ No this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 5 ☐ Pending 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident completely filled in by the 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide the Hospital or within 24 hours a

To the Funeral I 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Greenest Baltimore MD 2170 MEHROTEA 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 20 1:25 p ^M DOLORES BROWN 2009 August /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner N/A Baltimore 3037 Mallview Road 9. Birthplace (State or Foreign Country) New York If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, August 9 6. Sex 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** , 1942 Min. 1 □ M 2 🔀 F Months Days Hours New 67 **Director** 072-34-5984 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County show r items 23a or 28a-f shor 1 XYes 2 No Completed by Funeral Director Baltimore Maryland | Baltimore City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code be filed within 72 hours after death wintal Hygiene.

ad other than "natural", or items 23a event, the Mydical Evan from the Uset by United States 3037 Mallview Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: Black 1 ☐Yes 2 X No Specify: 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Ments Important: If Item 27 Is marked any Injury or other traumatic e Margaret E. Haynes-Jones Mortimer James H. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3037 Mallview Road, Baltimore, Maryland 21230 Brown/Son Edgar 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition August 21. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 Baltimore, Marylard 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 22. Name and Address of Facility Cremation Society of Maryland, Inc. 21. Signature of Funeral Service Licensee Amanda Heaston 299 Frederick Road, Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions if any later of the sequence of t Examiner Due to or as a consequence of and Due to (or as a consequence of). physician a sthe burial-t Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy performed?/ Yes 2/2/No 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 NO Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 □Yes 2 □ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760 Ö σ. Division of Vital Records,

with the Maryland

Baltimore, Maryland 21215-0036

and 2 should be lealth and Mental

this certificate within 24 hours after death.

To the Funeral Director: , completely filled in by the f

State Registrar

Medical

determined

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BAUTIMONE MD 21202 SM 227 32. Registrar' Signatus

t<mark>√ Certifying Physician:</mark> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

4 Homicide

29a. Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

onald Francis		1- For State	e of Maryland /		ent of neath	and Meni		eg. No. 200	9 2705
Physici	an/	Registrar 1. Decedent's Name (First, Middle,L	,				2. Date of Dea	th	3. Time of Death
Medical Exam	iner	Donald Franci			Lu ou T		Month August 18		2135 hrs
)		4a. Facility Name (if not institution, Baltimore Washington N	-		Glen Bur	, or Location or nie	r Death	4c. County of Death Anne Arundel	
Funeral		Social Security Number 6.	Sex 7. Age	(In yrs. last bir				th(MM/DD/YYYY) 9. Bit	
Director			X M 2 F	46 	Yrs. Months I	Days Hours	Min. April 1		untry Maryland
any	ŀ	Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town	or Location				10d. Inside City Limits
<u> </u>	٦	Maryland Anne A	rundel	G1	en Burnie				1 Yes 2 No
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5 72 hours after death with the Maryland n "natural", or items 23a or 28a-f shov al Examiner must be notified at once.		514 Crain High	12. Was Decedent E	ver in II S		1061	in? (Specify Yes or No	nited State	ican Indian, Black,
leath wi r items	Funeral	1 X Never Married 2 Marri	ed Armed Forces?	No No			Puerto Rican, etc.)	White, etc.	icell indian, block,
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212 Id be Menta narke	o Be	Arthur F. Barr 19a. Informant's Name/Relationship	(Type, Print)	19	b. Mailing Address (S		othy Davis	mber, City or Town, State	Zin Code)
MD 2 d 2 shot dth and d n 27 is a	٦	Dorothy M. Barr		19	•			is, Marylan	
	li	20a. Method of Disposition 1 Burial 2 X Cremation		20b. Place	of Disposition (Name of tory or other place)		ugust 21,	20c. Location - City or	
Baltimore, permit. Pages I as Department of He Important: If ite				Motro	Commete	T	2009	Baltimore,	Maryland
Baltimo permit. Page Department o Important: injury or oth		21. Signature of Funeral Service Lie	censee Amanda I	leaston	22. Name and Add	ress of Facility	Cremation S	Society of	Maryland, Inc
Physician	\exists	23a. Part I. Enter the disease, or co		ne death. Do n	ot enter the mode of dy	T1CK KC ing, such as ca	DAC, BALTIM ardiac or respiratory arr	ore, Maryla rest, shock, or heart	Approximate Interval
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		or condition resulting in death)	Due to (or as a conseq	uence of):					
	Je l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conseq	uence of):					
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: 68760, certificate be nding physici		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	of pregnancy ;	2 Fetal death	3 Ectopic	pregnancy	23d. Date of deliver Month	y Day Year
Box 687 The death certific the attending properties as the	Physician/	1 Yes 2 No 9 Unkno	4 Pregnant at til	me of death	5 Other (Specify)				
C th by		Part II. Other significant condition		out not resultin	g in the underlying cau	se given in Par	rt 1. 23e. Did to	obacco use contribute to	the cause of death?
F. P.O.	d by						1 Yes	s 2 No 3 Pro	bably 4 🗸 Unknown
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Rec The la icate h	မ္ပ					*	1 XYes	rmed? death?	es 2 No
Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medical examiner?	Hospital: 1	2 V ER/O	E 7	other	Check only one) Nursing Home 5	Residence 6 Other	
of Viring Physical After this funeral dir	1	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day, Yea	28b.		Injury at Work?		how injury occurred Struck by	
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Division of Vital Records, tal or Attending Physician: The law requires after death. al Director: After this certificate has been siled in by the funeral director, page 2 should be	ertification	3 Suicide 6 X Could n	ot be 28e. Place of Inju		arm, street, factory, offi	ce building, etc	or Town, S	State) Crain_Hw	ural Route Number, City y @ 6th Ave
Cospita fospita fours uneral	0	29a. Certifier	sician: To the best of my	her	ath occurred at the time	date and pla		urnie, MD	ted
Divis To the Hospital or A: within 24 hours after or To the Funeral Direct completely filled in by	Medical	(Oneon only	ner: On the basis of exami and manner stated.	-					
F.85.8	Me	29b. Signature and title of certifier	and mariner stated.			ense number		29d. Date signed (Mo	onth, Day, Year)
	ĺ	alles	Nes	//	7. 0.	C.M.E.		August 19, 2009)
10 Epoch		30. Name and address of person what Zabiullah Ali, M.D. As	no completed cause of deassistant Medical Exa		11 Penn Street, B	altimore, M	1D 21201		
	tate	31. Date file 1 6 7 2 5 2009	32. Registrar's	04	wed I			<u> </u>	
Regis	trar	400 × 0 5008	person 1	J. 1900					

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State of Maryland / Department of Health and Mental Hygiene

For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 9:00 P M 19, **ANDREW** BUECKER AUGUST 2009 HOWARD /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** FOREST HILL

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Feb. 16, FOREST HILL HEALTH & REHAB CENTER HARFORD Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Year 1 X M 2 □ F 1930 218-26-0072 79 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 ☐ Yes 2 No Director Maryland Bel Air Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21014 1000 Longstream Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Specify: <u>ک</u> 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retail Security Officer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ida Mae Dunken Andrew Benjamin Buecker ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Howard S. Buecker / Son 1000 Longstream Court, Bel Air, MD 21014 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Memorial Gdn. 8-24-09 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
McComas Funeral Home, P.A.
50 W. Broadway, Bel Air, MD 21014 of Funeral Service Licensee Clamas 23a. Part 1. Enter the his as a correspiratory arrest, shock, or heart failure. List only one cause on each line. **Hypertension** Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PAR Due to (or es a consequence of) years Chronic Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (of as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 2 □No 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of ath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Villaural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 615 W. MACPHAIL ROAD ROBERT DUNCAN 21014 BEL AIR, MD.

State Registrar 31. Date filed (Month, Day, Year) **AUG** 25 2009

Funeral

Director

28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Examment in the notified at

Physician

/Medical

Examiner

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funeral director, page 2 should be

24 hours after deatle Funeral Director: filled in by the

within 2.

Hospital

or Attending Physician: The law requires that the death certificate be executed

Box 68760.

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Records,

of Vital

Division

death with the Maryland

21215-0036

Maryland

Baltimore,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 12:15 PM Joseph Alfred Bucci August 21, 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Upper Chesapeake Medical Center Bel Air Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 1 M 2 □ F Director 216-28-5522 75 Mar. 6, 1934 Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Modes Evander to the product of any injury or other traumatic event, the Modes Evander to the product of the product of the modes Evander to the product of the modes Evander that the modes of the product of the modes of the mode 28a-f show 1 ☐ Yes 2 X No Director Bel Air Maryland Harford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 205 Kings Crossing Circle 21014 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1XXYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ∐Yes 2**X** No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Salesman 12 Beverage Distributor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Luciano (nmn) Bucci Jennie Marie Bianca 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 Kings Crossing Circle, Bel Air, MD 21014 Patricia Bucci / Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 8-24-09 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
McComas Funeral Home, P.A. alder athleen 50 W. Broadway, Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** bowil Small /Medical Due to (or as a consequence of): **Examiner** COPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Delydrelun attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown been signed by ti should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy 1 ☐ Yes 2 ☐ No 2 🕽 funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director; 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar

Medical

31. Date filed (Month, Day, Year) AUG 25 2009

WAJAHATH MUNSINI

29b. Signature and title of certifier

(Check only one)

500 upper cherepake or 32. Registrar's Signature

mD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

00067452

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29d. Date signed (Month, Day, Year)

21/09

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 7:25 PM **Physician** 19,2009 Diana Mae Bailey August /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Upper Chesapeake Medical Center Rel Air If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🔀 F Yrs July 26, 1950 Maryland 59 Director 213-60-6331 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1 ☐ Yes 2X No Director Maryland Aberdeen Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21001 3300 Churchville Road Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐Yes 2 XNo Specify: Specify: 2 3 ☑ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Supplies Bookkeeper 7 is marked other traumatic event, if 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental F Betty Jane Stamper Verlon Cleveland Wright ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 shr Department of Health and Important: If Item 27 is m: any injury or other traum: once. 3300 Churchville Rd., Aberdeen, MD 21001 Crystal D. Dziecichowicz / Dau. Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air, Maryland 8-25-09 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gdn. 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 21. Signature of Funeral Service Licensee Kathleen Willer CFSP, CPC Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Septic **Physician** 24 hours /Medical Due to (or as a lonsequence of): Examiner DC 06 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physician and s the burial-trans Due to (or as a consequence of). 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 No 5 ☐ Other (specify) Records, P.O. 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? certificate has been signed rector, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☑ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 □Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1⊉Yes 2 🗆 No this ၉ 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After t Certification: ..dl or At...
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in by the fur 1 Natural 2 Aecident 5 Pending 1 ☐Yes 2 ☐No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0053568

State Registrar

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31. Date filed (Month)

Day, Year)

Thompson, MD

17) 32. Begistrar's Signature

30. Name and address of person who impleted cause of death (Item 23a) (Type, Print) SOO UPPEr Che sape of

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Marigad

09-06435 Antoinette Bua

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Reg. No. Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Month Day August 17, 2009 Physician/ 0625 hrs Antoinette Maria Bua Medical Examiner 1c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) N/A **Baltimore** Sinai Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** oreiar Hours Months Days Mary land Jan. 17, Director M 2XXF unknown Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County any 1XX Yes 2 No Baltimore N/A Maryland 23a or 28a-f show notified at once. Pages I and 2 should be filed within 72 hours after death with the Maryland neut of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21224 8039 East Baltimore Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funeral White, etc. Armed Forces 1XX Never Married 2 Married Yes White Specify: Yes 2 No specify. Yes, Give Year Divorce Widowed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ≥ 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) N/A N/A Baltimore, MD 21215-0036 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Phvllis Sheridan Phillip J. Bua, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8039 East Baltimore Street, Baltimore, MD 21224 Phyllis Bua Mother 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Buria 2 X Cremation 3 Removal from State Glen Burnie, Maryland 8/24/2009 Atlantic Crematory ment tant: Donation 5 Other Specify 10 ²² Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21. Signature of Funeral Service Licensee 3631 Falls Road, Baltimore, Maryland 23a. Part I I finiter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and **Physician** Death Medical Asthma complicating narcotic intoxication Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Uniquilying Cause Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last 23a,PII,27,28a-f,perm,E g895 9/8/09 TT Physician/Medical AMENDED X UNPENDED physician a 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 5 Yes 2 No 9 ✔ Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Records, P.O. Yes 2 V No 3 Probably 4 Unknown þ Cocaine use Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed' has 1 🗸 Yes ✓ Yes 2 certificate 26.Place of Death (Check only one) 25. Was case referred to medical Be Other: examiner? Residence 6 Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Nursing Home 5 1 🗸 Yes ို 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27 Manner of Death Certification: Yes 2 X No unk 1 Natural Pending Fd 5:30 am Fd 8/17/09 To the Funeral Director: 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number of Route Number City of Town, State) 4107 W Forest Park 3 Baltimore, MD Suicide (Specify) Found: private dwelling determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier August 17, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ling Li, MD

State Registra

31. Date filed (Month

09-06458	
Sheri Gail Blum	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Baltimore permit. Pages I Department of I Important: If injury or other	4 Donation 5 Other Specify: ATTZ CHAIM CONG 08/23/2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVIN								NSON & BROS., INC.				
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Sion Attendideath. Sctor:			estigation	niumy - At h	ome farm street	factory office	Yes 2 No	28f. Location	(Street and Nu	ımber or Ru	ural Route Number, City		
Divis	Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. Suicide Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)											
y file		29a. Certifier 1 Certifying I	Physician: To the best of m	ny knowled	ige, death occurr	ed at the time,	date and place,	and due to the cau	ise(s) and mai	nner as stat	ed.		
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	-	AND Co	NA				C.M.E.		August	19, 2009			
	\mid	30. Name and address of person			n 23a)		A Dallin	MD 24224					
0:		Russell Alexander M 31. Date filed (Month, Day, Year					t, Baltimore,	NID 21201					
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #30 per byR 8894 8/25/09 TT State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 21, Month 2009 **Physician** 3:23 PM Carroll August Virginia Covington /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/26/1935 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 74 424-40-2521 AR Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b County 10c. City, Town or Location 10a, State d other than "natural", or items 23a or 28a-f show event, the l'adical Expenient must be notified a D.C. Washington MYes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with USA 4201 Butterworth Terrace NW Apt.445 20016 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 □Yes 2 XNo Specify Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) 5+ College Teacher Education f Health and Mental Hygier Item 27 is marked other th other traumatic event, Inc 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Weaver Covington, Sr. Maude Belle Carroll ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jeannette C. Willis/Sister 29 Shiloh Drive, Sylacauga, AL 35151 permit. Pages 1 and Department of Health Important: If item 27 any Injury or other troonce. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 8/25/2009 Hanover, MD Ardent crematory 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility Maryland Cremation Services oute a: Marshall PO Box 1413, Baltimore, MD 21203 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OBSTRUCTIVE PULMONARY **Physician** 0150 AS 15 a. CHRONIC /Medical Due to (or as a consequence of) Examiner NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe ovington, Vingina 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Yes 2 | 1√0 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 11 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in ≠ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Reno 1 ms 00057124 8/12/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Trung Bao, MD 10110 Molecular Dr. #206 Rockville, MD 20850 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

AUG 25

8/21/09

new

			State Registrar	State of Ma	rylan		rtmen			and M		Reg. No.	2009	27	072
	Physici	an	Decedent's Name (First, Middle, Last)									Month Day Year			of Death
	/Medio		Lorraine Celestia Cammarata 4a. Facility Name (If not institution, give street and number) Stella Maris 4b. City, Town, or Location of Dear Lutherville												A M
Ĩ	Funeral Director		Stella Maris 5. Social Security Number 6. Sex 172-24-8248	7. Age	(In yrs. 1	last birthday) Yrs.	If Under Months		If Under	24 Hrs. Min.	8. Date of Bir (Month, Da 09/05/	th av. Year)	9. Birth		e or Foreign
ST 22, 2009 9:27 a.m ore, Maryland 21215-0036	after death with the Maryland or items 23a or 28a-f show	Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland 10e. Street and Number 904 "F" Cedar Crest 11. Marital Status 1 Never Married 2 Married	ation 10f. Zip Code 21040 Was Decedent of Hispanic Origin? (Specil Yes, specify Cuban, Mexican, Puerto Ric				1 □ \ 10g. Citizen of What Country? U.S.A. cify Yes or No- Rican, etc.) 14. Race - American Indian Black, White, etc.			intry?	es 2 XD Mio			
	12 should be filed within 72 hours after hand Mental Hygiene. 7 is marked other than "natural", or ite traumatic event, the Modical Evanina.		15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12) 8 17. Father's Name (First, Middle, Last) Jason George Jones	Year or Dates: 16a. Deced			18. Mother's Name			king		· ·			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To	19a. Informant's Name/Relationship (Type Christine Parrish (20a. Method of Disposition Burial 2 Cremation 3 Red 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	Daughter	20b. P	8603 I lace of Disposemetery, cren 11y Hi	Manor sition (Nan natory or o	(Street a fiel ne of ther place m. G	and Number	ad, N	al Route Numb Notting Date 5/2009	ham, 20c. Loc Balti	Marylar cation - City or Town, State, 2 Marylar cation - City or Towns, More, More, P. Fex, Mary	nd 212 Town, State Maryla	nd
ox 68760,	certific	n/Medical Examiner	d											3etween	
LORRAINE CAMMARATA Division of Vital Records, P.O. Box all or Attending Physician: The law requires that the death cert	The law ate has b	Completed by Physician/Med	in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown Part II. Other significant conditions contr	1 Live birth 2 4 Pregnant at 9 Unknown buting to death bu	time of d	leath 5	Ectopic p	ecify)	en in Part I.		1 □ 24a. Wasauto perfo 1 □ Yes	Yes 2[an psy primed? 2 X No	Month se contribute to No 3 Pr 24b. Were au prior to c death? 1 Yes	topsy finding	Unknown gs available
	To the Hospital or Attending Physician: The law requin within 24 hours after death. To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should	Certification: To Be	25. Was case referred to medical examiner? 1					28c. Injury at Work? M 1 Yes 2 No et, factory, office 28d. Describe how injury occu 28f. Location (Street and Num. City or Town, State)					occurred Number or Ru	ırred	
6	To the Hospital within 24 hours To the Funeral completely filled	Medical		r: On the basis of interner state. August 1997 Pletted cause of de	examina ted.	tion and/or in	290 Print)	License	pinion, dea	nth occur	red at the time	29d. Date		to the caus	
	Sta Registr		JACKIE JONES, CRN	2 2300 L 32. Registra	r's Signa	VEY, VAI	uty ale	.	TIMO	NLUM	MD 2	1093			

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** : 22 A M August 2009 Carrel V /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** f Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Multi-core K-es wick 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex If Under 1 Year **Funeral** Days 1□M 2**X**F Hours Country) MD 218-14-0998 Yrs. Director November 06, 1923 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location XXXX es 2 No MD N/A Baltimore Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21211 3022 Darby Street Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ X O If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📆 💢 No Specify: White Ş Q 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Weaver Mt Vernon Mills 9th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be Theodore Childs Alice Gertrude Evert ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Fred Carnell, Sr. (Husband) 3022 Darby Street Baltimore, MD 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1XXXIII 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Cemetery 8/27/09 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licens Hurgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Balto, MD 21211 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pre-renal itzoternia resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by þe 2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ▼No 24a. Was an has funeral director, page 2 autopsy performed certificate 2 No No No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient Medical Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death **Fo the Funeral Director:** 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide Decritying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi 00061199 August 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Black

Sasco

31. Date filed (Month, Day, Year)

St. Suite 4105, Tousan MD

North Chorles

32 Registrar's Signature

6701

	Do.	For State	of Maryland / Department Certificate	of Death	Reg. No 2. Date of Death	20	3. Time of Death
Physician lical Examine	1. er	Decedent's Name (First, Middle, Last Melod)	y Crawley	- Control	Month Day August 20, 200	Year)9 c. County of Death	1717 hrs
	4a	a. Facility Name (if not institution, given 1816 E. 30th Street	street and number)	4b. City, Town, or Location of Death Baltimore		N	IA
Funeral	5.	Social Security Number 6. Se	ex 7. Age (In yrs. last birthday	y) If Under 1 Year If Under 24Hrs Months Days Hours Min.	8. Date of Birth (MM	Foreig	thplace (State or untry) Maryland
Director		216-08-9678 1 sual Residence of Decedent	M 2 F 27	Yrs.	1171.00,1	760 00	
w any	_	Oa. State 10b. County	10c. City, Town or L	Battimore			1 Yes 2 No
death with the Maryland or items 23a or 28a-f show must be notified at once.	Director	0e. Street and Number		10f. Zip Code 21218	10g. C	itizen of What Cou	ntry?
ith the N 23a or notified		1816 E, 30H	12. Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - Amer White, etc.	ican Indian, Black,
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ural", c	<u>a</u>	Widowed 4 Divorced 15. Decedent's Education (Specify of	d If Yes, Give Year or Dates: only highest grade completed) 16a. Dec	cedent's Usual Occupation (Give kind of ing most of working life. DO NOT use ref		. Kind of Business	/Industry
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Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health and N Important: If item 27 is n injury or other traumatte	1	4 Donation 5 Other Specification 21. Signature of Funder of Service Lice	y:	2. Name and Address of F cility	Ker Fyne	mal Hor	Ne PA, 2/2
m ឧក្ខំ <u>គ</u> ្គើ Physician	\dashv	23a. Part I. Enter the disease, or cor	mplications that caused the death. Do not e	enter the mode of dying, such as cardiac	or respiratory arrest,	shock, or heart	Approximate Interval
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ammer		or condition resulting in death)	Due to (or as a consequence of): b.				
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of):				
Jk, balu	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):				
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of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be exect After this certificate has been signed by the attending physician an uneral director, page 2 should be detached for use as the burnal -u	Certification: To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 ✓ Unkno Part II. Other significant condition Seizure diso 25. Was case referred to medical examiner? 1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Pendin 1 Natural 2 X Accident Investig 3 Suicide 6 Could determ 4 Homicide	Hospital: 1 Inpatient 2 ER/Out 28a. Date of Injury (Month, Day, Year) Fd 8/20/09 Fd 28e. Place of Injury - At home, far inned (Specify) 1 Live birth 2	Other (Specify) in the underlying cause given in Part I. 26.Place of Death (Che stratient 3 DOA Other, Nu Time of Injury 28c. Injury at Work? 1 Yes 2 X No Imm, street, factory, office building, etc. idence	23e. Did tobs 1 Yes 24a. Was an autopsy perform 1 Yes 2 28ck only one) 28d. Describe hor subject 28f. Location (St or Town, Stalltimor	2 No 3 F yet and Number of steel 1816 E. (a) and manner as	Probably 4 Unknown a autopsy findings availat to completion of cause of Yes 2 No ther: Scene ested alcoho Rural Route Number, C 30th St
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be exect. After this certificate has been signed by the attending physician an uneral director, page 2 should be detached for use as the burnal -u	Certification: To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 ✓ Unknot Part II. Other significant condition Seizure diso 25. Was case referred to medical examiner? 1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Pendin 1 Natural 2 X Accident Investigning 1 Note 1	Hospital: 1 Inpatient 2 ER/Ou 2 ER/Ou 2 ER/Ou 28a. Date of Injury (Month, Day, Year) 19 Gation 10 Live birth 2	26.Place of Death (Che stpatient 3 DOA Other 4 Nu Time of Injury 28c. Injury at Work? 5:00 pm 1 Yes 2 X No Injury at Work? 1 Yes 2 X No Injury at Work? 1 A Yes 2 X No Injury at Work? 1 A Yes 2 X No Injury at Work?	23e. Did tobs 1 Yes 24a. Was an autopsy perform 1 Yes 2 28ck only one) 28d. Describe hor subject 28f. Location (St or Town, Stalltimor	2 No 3 F yet and Number of tate) 1816 E. yet and Number of tate) 1816 E.	Probably 4 Unknown a autopsy findings availat to completion of cause of the steel 2 No ther: Scene 2 steel alcoho Transl Route Number, C 30th St Stated. To the cause(s)
Vital Records, P.O. Box 68760, sistem : The law requires that the death certificate be executive certificate has been signed by the attending physician an director, page 2 should be detached for use as the burial - to	Certification: To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 ✓ Unkno Part II. Other significant condition Seizure diso 25. Was case referred to medical examiner? 1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Pendin 1 Natural 2 X Accident Investig 3 Suicide 6 Could determ 4 Homicide	Hospital: 1 Inpatient 2 ER/Ou 28a. Date of Injury (Month, Day, Year) Fd 8/20/09 Fd 28e. Place of Injury - At home, fair (Specify) 28b. T resident: To the best of my knowledge, dealiner: On the basis of examination and/or in	Other (Specify) in the underlying cause given in Part I. 26.Place of Death (Che stratient 3 DOA Other, Nu Time of Injury 28c. Injury at Work? 1 Yes 2 X No Imm, street, factory, office building, etc. idence	23e. Did tobs 1 Yes 24a. Was an autopsy perform 1 Yes 2 28ck only one) 28d. Describe hor subject 28f. Location (St or Town, Stalltimor	2 No 3 F yet and Number of steel 1816 E. (a) and manner as	robably 4 Unknown a autopsy findings availat to completion of cause of Yes 2 No ther: Scene ested alcoho r Rural Route Number, C 30th St stated. to the cause(s) (Month, Day, Year)
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be exect After this certificate has been signed by the attending physician an uneral director, page 2 should be detached for use as the burnal -u	Certification: To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknot Death II. Other significant condition Seizure diso 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin Investing Suicide 6 Could determ 3 Suicide 6 Could determ 4 Homicide 29a. Certifier 1 Certifying Phyone) 2 Medical Exam 29b. Signature and title of certifier	Hospital: 1 Inpatient 2 ER/Ou 28a. Date of Injury (Month, Day, Year) Fd 8/20/09 Fd 28e. Place of Injury - At home, fair (Specify) 28b. T resident: To the best of my knowledge, dealiner: On the basis of examination and/or in	Other (Specify) in the underlying cause given in Part I. 26.Place of Death (Che utpatient 3 DOA Other4 Nu Time of Injury 28c. Injury at Work? 1 Yes 2 X No irm, street, factory, office building, etc. idence ath occurred at the time, date and place, investigation, in my opinion, death occurre 29c. License number	23e. Did tobs 1 Yes 24a. Was an autops, perform 1 Yes 2 eck only one) rsing Home 5 R 28d. Describe hose or Town, Stand due to the cause ed at the time, date a	2 No 3 F yet and Number of tate) 1816 E. (s) and manner as and place, and due to 29d. Date signed	robably 4 Unknow a autopsy findings availat to completion of cause of Yes 2 No ther: Scene ested alcoho r Rural Route Number, C 30th St stated. to the cause(s) (Month, Day, Year)

DHMH 17 Rev 1/2001 OCME 2006

OCME

	1 - State of Maryland / Department of Health and Mer Certificate of Death	ntal Hygiene Reg. No. 2 0 0 9 2 7 0 7 5
sician		Date of Death Month Day Year 3. Time of Death
edical	-	ugust 16,2009 09304 M
miner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 1008 ScottsHill Drive Pikesville	4c. County of Death Baltimore
ral tor	MONTHS Days Hours Min.	Date of Birth (Month, Day, Year) an.10,1935 9. Birthplace (State or Foreign Country) SouthCarolin
	Usual Residence of Decedent	
once. To Be Completed by Funeral Director	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
Funeral Director	SouthCarolina Sum ter Olanta	1 □Yes 2 □ No
Dir	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
era.	5195 Narrow Pavel Road 29114	U.S.A.
Ë	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	y Yes or No- an, etc.) 14. Race - American Indian, Black, White, etc.
2	If Yes, Give 1 Li Yes No Specify: 3 X Widowed 4 □ Divorced Year or Dates:	Specify: Black
ted	15. Decedent's Education 16a. Decedent's Usual Occupation	16b. Kind of Business/Industry
plan	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of working life. DO NOT use retired)	
Completed	9 Laborer	Cement Company
Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)	irst, Middle, Maiden Surname)
2		Cellista Frazier
		oute Number, City or Town, State, Zip Code) 21 208
		e, Pikesville, Maryland 20c. Location - City or Town, State
	11/2 Burisl 2 Cramation 3 Removal from State cemetery, crematory or other place)	
	4 Donation 5 Other (Specify) New McFaddenCemetery 8-22	Olanta, SouthCarolin
	The colored All has little	ullo Funeral Chapel, P. A
	23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or re	Baltimore, Maryland2121
	shock, or heart failure. List only one cause on each line.	Interval Between
	Immediate Cause (Final disease or condition resulting in death) a. ArJanos cl Protic Carolovas Cu Due to (or as a consequence of):	an OI Seasel
r	Due to (or as a consequence of).	
je	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	
Examiner	Cause (Disease or injury that initiated events c.	
Ex	resulting in death) Last Due to (or as a consequence of):	
dical	d	
Mec	IF FEMALE:	
Physician/Me	23b. Was decedent pregnant in the past 12 months?	23d. Date of delivery Month Day Year
Sic	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown	Month Say You
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
l b		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown
Completed		
100		24a. Was an autopsy autopsy prior to completion of cause of death?
S		performed? death? 1 □ Yes 2 No 1 □ Yes 2 No
Be	25. Was case referred to medical examiner? Hospital: Other: Other:	
7	1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Home	-21
io	Natural 5 Pending (Month, Day, Year) Injury Work?	d. Describe how injury occurred
Cal	3 Suicide 6 Could not be 380 Place of Injury. At home form street factors office.	. Location (Street and Number or Rural Route Number,
Certification: To	4 Homicide determined determined building, etc. (Specify)	City or Town, State)
	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and	d due to the cause(s) and manner as stated.
Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	
Me	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
	MI DO DULL NOVICE	August 11 2000
	I I A A A A A A A A A A A A A A A A A A	
1	30. Name and address of person who completed cause of death (Item 28a) (Type, Print)	August 16,2009
	30. Name and address of person who completed cause of death (Item 28a) (Type, Print) Philip Militello MD & Trumble Hill CT Luther	wille 1083
State	30. Name and address of person who completed cause of death (Item 28a) (Type, Print) Philip Militello MD (Trumble Hill T Luther 31. Date filed (Month, Day, Year) 33. Registrar's Signature	willer 16/21083

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

Marzullo Funeral Chapel, P. A. Certification: after death

Director: 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hour⊾ the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatu d title of certifie 23 2009 August HOOG6481 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr.Matthew Levy 5755 Cedar Lane, Columbia, Maryland 21044 31. Date filed (Month, Day, Year) State AUG 25 2009 Registrar DHMH 17 Rev 1/2001 ORIGINAL

Amend #9 per Fh g894 8/25/09 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar	State of	Marylan		artment of H		ind Men		iene () () 9	27077
	Physicia	n	1. Decedent's Name (First, Middle,	Last)) (h					Date of Deat Month	h Day Ye	0 1220 PM
	/Medic Examin		SYIVIZ (a. Facility Name (If not institution, s	rive street and nun	nber)	(5m. /x	4b. City, Town, or	Location o	f Death	1208	4c. County of D	
	Funeral				7. Age (In yrs. I		If Under 1 Year Months Days	If Under a		Date of Birth Month, Day,	Year) 9.	Birthplace (State or Foreign Country) NY
	Director ≥	-	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation			. 08	1 (17)	10d. Inside City Limits
	e Maryla Ba-f shor	ctor	mb Ba	160		011	sville				0g. Citizen of What	1 Yes 2 1
	er death with the Maryland Items 23a or 28a-f show net must be notified at	Funeral Director	10e. Street and Number 725 mt	wilson	6		10f. Zip Code				U	SA
980	or Ite	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	Armed Fo	2 MNo	1	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin, Mexican Specify:	gin? (Specify , Puerto Rica	Yes or No- in, etc.)	Black, V	American Indian, Vhite, etc. Wh (Te
Maryland 21215-0036	within 72 hours ene. than "natural", he wedical Ex	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12	Education grade completed) College (1	-4or 5+)	(Give life.	dent's Usual Occupi kind of work done o DO NOT use retired	durina mosi	t of working		16b. Kind of Busine	
and 2	be filed Ital Hygi od other event, t	Be	17. Father's Name (First, Middle, La	ist)	TACKEL	11011	LITAKLK	18. Mothe		rst, Middle, I	Maiden Surname)	ENFARB
Mary	2 she and is m	-	19a. Informant's Name/Relationshi		MOREZ			and Numbe	er or Rural Ro		, City or Town, Sta	te, Zip Code)
	9 2 5		JANICE STRAUSS/D 20a. Method of Disposition 1 X Burial 2 □ Cremation	B □Removal from	State	Place of Dispo emetery, crea	sition (Name of matory or other plac	(8)	Date		RE MD 2'	y or Town, State
Baltimore,	permit. Pag Department Important:: any injury c		' 4 □ Donation 5 □ Other (Special Service Li		DEI	22	2. Name and Addres	ss of Facilit	y SOL I	EVINS	ON & BRO	STOWN, MD THERS, INC. , MD 21208
	Physician		23a. Part1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final disease or condition	omplications that conly one cause on e	aused the deat							Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Sequentially list conditions,	Due to	(or as a conseq		1 Cer					unknown
	cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c. D	ebili	ty						unknown
8760,	ate be executed hysician and the burial-transit	cai	resulting in death) Last	d	(or as a conseq	uen > of):						
P.O. Box 68	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1☐Live t	tcome of pregna birth 2 Teta nant at time of co	Il death 3	□Ectopic pregnancy □ Other (specify) _	1			23d. Date o Month	f delivery Day Year
ds, P.	luires that t n signed by Ild be deta	d by Ph	Part II. Other significant condition	es contributing to d	eath but not res	sulting in the u	ınderlying cause gıv	en in Part I	l.		obacco use contribu 'es 2 □ No 3 [te to the cause of death?
Division of Vital Records,	The law requires tha ste has been signed page 2 should be de	Completed								24a. Was a autop perfor	sy prio rmed? dea	re autopsy findings available r to completion of cause of th? Yes 2 \sumbox No
Vita	rsician: Th s certificate director, pag	To Be C	25. Was case referred to medical examiner?	Hospital: 1 🗆	Inpatient 2] ER/Outpatie	nt 3□ DOA Oth		e of Death (Cursing Home		ne) lence 6 □Other	(Specity)
on of	ding Phys h, After this funeral di	tion: T	27. Manner of Death 1 Natural 5 Pending investige		of Injury eth, Day Year)	28b. Time of Injury	Wor	yat rk? Yes 2 □		I. Describe h	ow injury occurred	
Division	I or Attendi after death. Director: A I in by the fu	Certification:	2 Accident investig. 3 Suicide 6 Could n 4 Homicide determin	ot be 28e. Place	e of tnjury - At h ing, etc. (Speci	ome, farm, si	reet, factory, office		28f	Location (S City or Tow	Street and Number vn, State)	or Rural Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certifying (Check only one) 1 Medical E	xaminer: On the b	e best of my kno basis of examina oner stated.	owledge, dea ation and/or i	th occurred at the tinvestigation, in my o	me, date a opinion, dea	nd place, and ath occurred	due to the dat the time, d	cause(s) and mann date and place, and	er as stated. I due to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	10 m xi fo	M	CRA	P RD	se number	41 p	12	29d. Date signed (1	Month, Day, Year) - 2009
_			30. Name and address of person v	who completed cau	se of death (Ite	m 23a) (Type	Print) mD	2	1136	0		
	Sta Regist	ate rar	31. Date tiled (Month, Day, Year)	32,1	Registrar's Sign	ature	. d.l					
	ricgist	-en	AUG 25 2	009 Kkm	was p	1. 400	N.Co.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** DRENCE 0 VUIC 0 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) (Tate Examiner Hospice of the Chesapeake Baltimore Linthicum House) 8. Date of Birth (Month, Day, Yea 1an. 27, 9. Birthplace (State or Foreign Country)
PA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. **Funeral** Year) Days Hours 1 M 200F 72 222-22-0429 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Exercited at 1 □ Yes 24 No MD Baltimore Lansdowne Director permit. Pages 1 and 2 should be filed within 72 hours after death with the I Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a any Injury or other traumatic event, Ite Medical Eventual to rother traumatic event, Ite Medical Eventual to rother Citizen of What Country? 10g. Citi USA 10e. Street and Number 306 Mardo Ave. 10f. Zip Code 21227 Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 No
If Yes, Give 1 ☐ Never Married 2 ☐ Married White 1 □ Yes 2 📈 No Baltimore, Maryland 21215-0036 Specify: Completed by 3 ☐ Widowed 4 X Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last)
Patrick Walsh 18. Mother's Name (First, Middle, Maiden Surname) Be Margurite Brennen 2 19b2 Nation Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) 21228 Robert Delivuk, son Print) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State West Arundel Crematory 08-25-2009 Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ambrose funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne, MD. 21227 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Derr Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of): Examiner law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760. Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3

Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown P.0. the detached signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed certificate 2 No 1 □Yes 2 No 1 □ Yes Division of Vital Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 40USC After 1 Certification: or Attending 1 Natural 2 □ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and mapper stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) pm M 441 32. Registrar's Signature 31. Date filed (Month, Day, State

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			for State Registrar	State of Mai	ylanu / L		icate of L	Death		Reg. No.	00	27079
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath Day	Year	3. Time of Death
	Physicia /Medic		Barbara			Davi			Augu.	st 22,	2009	2:23a M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b		Location of Death		4c. County		
			4057 St. Moni					undalk			altim	
П	Funeral		5. Social Security Number 6. Se	X 7. Age	(In yrs. last bii		Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	ıy, Year)		lace (State or Foreign try)
	Director		213-54-4487 Usual Residence of Decedent		61	115.			November	27, 1947	$_Virg$	pinia
	and Jw		10a. State 10b. County		10c. City, Tow	n or Location	on				10	Od. Inside City Limits
	Maryl f sho	ō	Md. Baltin	опе			Dundalk	1				1 □Yes 2 No
	the 1	rec	10e. Street and Number		-	1	Of. Zip Code			10g. Citizen of	What Count	try?
	3a or	Funeral Director	4057 St. Monica	Daine				21222			USA	
	death ms 2	ner	11. Marital Status	12. Was Decedent Ev	er in U.S.	13. Was	Decedent of H	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No	14. Rac	ce - America	
9	after or ite	F	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ∐Yes 2 ☑ No If Yes, Give			s,specily Cuba Yes 2. 1⊋No	Specify:	Tilcari, etc.)		ck, White, e fy: <i>Whit</i>	
5	ral",	d by	3 ₩ Widowed 4 □ Divorced	Year or Dates:		1.0	200	opeany.				
5-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, it is Mydical Examer and be nothered.	Completed	15. Decedent's Edu (Specify only highest grad	ication le completed)	16a	(Give king	s Usual Occup of work done	during most of work	ing	16b. Kind of B	usiness/Ind	ustry
7	/ithin ine. han '	ם	Elementary/Secondary (0-12)	College (1-4or 5+) V		NOT use retired Operati			Olli	ce Mana	I.CIP.T.
Z	e filed w al Hygie other t vent, th		12 years 17. Father's Name (First, Middle, Last)			1.07	Operand	18. Mother's Name	e (First, Middle	l		.930
yland	be od o	Be							hy Zitt		,	
	d 2 should th and then ?7 Is marke traumatic	မ	Raymond Burns 19a. Informant's Name/Relationship (T.	ivne Print)	194	Mailing A	ddress (Street	and Number or Rur	O	-	. State. Zip	Code)
_ ∑	d 2 sh th and ?7 Is m traum		Rob Robbins	Son		_		en Circle, E				111
a,	s 1 and 2 soft Health a item 27 ls		20a. Method of Disposition	00/2			n (Name of ry or other plac		Date	20c. Location		wn, State
Baltimore, Mar	permit. Pages 1 and Department of Health Important: If item 27 any injury or other to		1 ☑ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify				ny or omer plac Nemorial	e) August 200	10,	Midd	le Rive	on. Mi
≣	artm ortar		21. Inal re of Funeral Service Licens		20	22. Na	me and Addre	ss of Facility				29, 12
ñ	Depa Impo any Ir		mitrony	(1911 me	XXU	4 997	zelly Fyr	reral Home (H Dundali	ka Post 2	1222	
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused t	he death.	not enter th	ne mode of dyir	ng, such as cardiac	or respiratory a	rrest,	ACTION IN	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Breas								Onset and Death
	/Medical		resulting in death)	a. Due to (or as a								
	Examiner		Sequentially list conditions	b								
	D ##	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence	of):						
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a	ooneoguanee	of):						
60,	rtificate be executed ng physician and as the burial-transit			Due 10 (01 us u	consequence	J.).						
68760	icate phys the	ledical		d								
×	£ 5, a		IF FEMALE:	23c. If yes, outcome of						23d, Da	ate of delive	ery
POX	death ceri e attendin d for use a	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at			topic pregnanc her <i>(specify)</i> _	;y		М	Ionth	Day Year
О	w requires that the de been signed by the should be detached	Physician/	9 Unknown	9 Unknown								
	The law requires that the ate has been signed by thoage 2 should be detache	by P	Part II. Other significant conditions co	entributing to death bu	not resulting	n the unde	lying cause giv	en in Part I.	23e. Did	tobacco use cor	ntribute to th	he cause of death?
Records,	quire en sig uld b	Pd L	Glanus Tumar						1 🗆	Yes 2 □ No	3 P 6b	oably 4 ☐ Unknown
ပ္တ	m 0) a.	pet	COPD						24a. Was		. Were auto	psy findings available mpletion of cause of
Ť	The late has	Completed							perfe 1 □ Yes	ormed?	death?	2 □No
Vita	sician: The la certificate ha irector, page 2	Be	25. Was case referred to medical examiner?					26. Place of Deat	th (Check only	one)		
0	<u>~</u> . <u>e</u> .g		1 ☐ Yes 24 ☐ No	-	nt 2 ER/C			4 Li Nursing He		idence 6 🗆 Of		ý)
ב		<u>e</u>	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day		Time of Injury	28c. Inju	K?	28d. Describe	how injury occu	rred	
Sio	eat sat	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		o. At home f			Yes 2□No	28f Location	(Stroot and Num	hor or Bur	al Route Number,
Division	or Attendatter deatl	Certification: To	4 ☐ Homicide determined	building, etc	(Specify)	aiiii, sireei,	lactory, office			wn, State)	Der of Flara	y route rramos,
	spital ours neral filled		29a. Certifier 1 Certifying Ph	ysician: To the best o	f my knowledg	e, death o	curred at the ti	ime, date and place	, and due to the	e cause(s) and r	nanner as s	stated.
	To the Hospital or Atti within 24 hours after de To the Funeral Directi completely filled in by t	Medical	(Check only 2 Medical Examone)	iner: On the basis of and manner sta	examination a ed.	nd/or inves	tigation, in my	opinion, death occu	rred at the time	, date and place	, and due to	o the cause(s)
	Vithir vithir comp	Me	29b. Signature and title of certifier		M1		29c. Licens	se number		29d. Date sign	ed (Month,	Day, Year)
			la				- 40	058893	•	24 Au	gust	2009
	121		30. Name and address of person who o	Bayvie		(Type, Prin		nter	Balte	more,	MD	21224
	Sta Registi		31. Date filed (Month, Day Car) 25	32. Registra 2009 Line	r's Signature	1. 1	harrens					
						4.4						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) EVERITT MARIE - ROSE AUGUST 22 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death GENESIS BRIGHTWOOD Baltimore Lutherville If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Y Dec. 28, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year 1 ☐ M 2 🗙 F 83 Yrs Dec. France 219-58-6414 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 1 ☐ Yes 2¥☐ No Lutherville **Baltimore** Md. 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21093 117 Dublin Drive USA 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Education French Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Guillemin Marguerite A. Jean-Jacques Marius Mouton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 117 Dublin Dr. Lutherville, Md. 21093 Mr. Daniel Everitt/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cemetery | 8-27-09 Pikesville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Prvice Licenses 22. Name Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CORONARY ARTERY DISEASE Due to (or as a consequence of) Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Quality (or as a nonsequancy of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ ✓ ✓ autopsy performed? 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Examiner law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

Examiner

Physician/Medical

Completed

Be

Certification:

Medical

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Physician /Medical

burial-transit

signed by the attending physician the detached for use as the buria

this funeral

After

Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) State Registrar

29a. Certifier

29b. Signature and title of certifier

32_Registrar's Signature

for Awuch, MO

ORIGINAL

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D0061789

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOPPAINE OF ORI-ANDIAN. 5430 CAIMPBELL BLVD, STE214. BALTIMORE MODIBLE

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) August 22, 2009^{ear} **Physician** 8:25 A M Alfred Eckbauer /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Cecil Laurelwood Nursing Home Elkton Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min. 1 → M 2 □ F Months Hours Germany 4/9/1932 Director 319-30-3772 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Evantine must be motified at 1X Yes 2 No Director Aberdeen MD Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21001 U.S.A. 385 Oxford Ave. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🐴 No 11. Marital Status 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: Specify: White \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0·12) College (1-4or 5+) Electrical Engineer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alois Eckbauer Anna Jubyle ၉ 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 ment of Health a ant: If item 27 is 21001 385 Oxford Ave. Aberdeen, MD Anneliese Gray (Sister) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages Department of Important: If It any injury or or 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 8/24/09 West Chester, PA R. A. Ferris & Co. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A. 21. Signature of Funeral Service hicensee 21001-3399 Aberdeen, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final END STAGE ROWN **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for P.0. 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ፩ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown ficate has been si r, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 🖪 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 📉 No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physicial: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s). 29a. Certifier Medical On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title D54073 09 191 on who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe ONE COMPUNION OR SUIT 105 MONAMIE DE 19713 32 Registrar's Signature 31. Date filed (Month, Day, Year) State AUG Registrar

09-06472

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ohn Fetters	State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. 2009 2700
Physician/ Medical Examine	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year August 18, 2009 3. Time of Death 2301 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death St. Agnes Hospital 4c. County of Death N/A
Funeral Director	5. Social Security Number 171-36-4938 7. Age (In yrs. last birthday) 17. Age (In yrs. last birthday) 17. Age (In yrs. last birthday) 18. Days Hours Min. Teb. 7, 1941 Foreign Country) PA
Aaryland 28a-f show any 1.at once. ector	Usual Residence of Decedent 10a. State
the Maryland a or 28a-f sh tifted at once	10e. Street and Number 128 American Ave. 10f. Zip Code 21227 USA
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygeine. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 3 Widowed 4 Divorced 3 Never Married 2 Divorced 3 Never Married 3 Divorced 4 Never Married 3 Never Married 3 Never Married 4 Never Married 5 Never Married 6 Never Married 7 Never Married 8 Never Married 8 Never Married 9
5-0036 ed within 72 hours a sygiene. other than "natura the Medical Exami Completed b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Decedent's Usual Dccupation (Give kind of work done during most of working life. DO NOT use retired) Salesman 16b. Kind of Business/Industry Tate Engineering
215-0036 be filed within 7 mial Hygiene. rked other than ent, the Medica Be Compile	17. Father's Name (First, Middle, Last) James Fetters 18. Mother's Name (First, Middle, Maiden Surname) Catherine Graelish
MD 21 dd 2 should 1 ulth and Mer m 27 is mar aumatic ev	19a. Informant's Name/Relationship (Type, Print) James Fetters, son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11614 Sun Circle Way Columbia, MD. 21044
Baltimore, MD 2 permit. Pages 1 and 2 shou Department of Health and M Important: If item 27 is n injury or other traumatic	20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, Atlantic Crematory) 20c. Location - City or Town, State 08-25-09 Glen Burnie, MD
Balt permit. Departi Import injury	21. Signature of Euneral Service Licensee 22. Name and Address of Facility al Home of Lansdowne Amorose Funeral Home of Lansdowne, MD. 2122
Physician /Medical xaminer	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Approximate Interval Between Onset and Death Death
je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause
50, te be executed vysician and burial - transit	Citizense or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.
60, Ite be executed hysician and e burial - transit	UNPENDED AMENDED
ox 687(eath certifical attending plant for use as the size of the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown
P.O. B res that the d signed by the be detached d by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 V No 3 Probably 4 Unknown
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that th within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detach edical Certification: To Be Completed by P.	24a. Was an autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
Vital Rechysician: The this certificate I director, page Cope	25. Was case referred to medical examiner? 1
ion of Virtending Physicath. tor: After this the funeral direction: To After additional directions.	27. Manner of Death 1 Natural 5 Pending 2230 hrs 28a. Date of Injury 2230 hrs 28b. Time of Injury 225c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred Pedestrian struck by motor vehicle(s)
Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune redical Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Local Street 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2400 Hammonds Ferry Road, Baltimore, Md.
To the Hospital within 24 hours: To the Funeral completely filled	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
F 3 F 3	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 19, 2009
J^	30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
State Registra	31. Date filed (Month, Day, Year) 32. Degistrar's Signature
DHMH 17 Rev 1/2001	ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 19b per Th 8894 8-25-09 vt. State of Maryland / Department of Health and Mental Hygiene [] [] 1- State Amend Item#10e,f,19b,perINF,G895,9/10-09till Sate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Mattie S. Footman 1:03 AM OS 7009 /Medical 4a. Facility Name (If not institution, give street and number) 2401 w Bluela 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SINAL HOSPITAL OF BALTIMORE Baltimore Patract Knasnas Mattie Footman If Under 1 Year If Under 24 Hrs. Months Days Hours Min 8. Date of Birth (Month, Day, Year) Feb. 19, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** 1932 Maryland 1□M 2√F Months 214-44-2863 Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "naturel", or iteme 23a or 28e-f show other treumatic event, the Mcdical Examiner man be natified at Yes 2 No Baltimore N/ADirecto Maryland 10e. Street and Number Springdale 3500 Springfile 10g. Citizen of What Country? 10f. Zip C21216 USA bringfield Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1X Never Married 2 Married Specify: Black 1 ☐ Yes 2 DXNo Specify: þ 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bayview Hospital Housekeeping 5th grade t of Health and Mental Hy, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lottie Carlies 2 Emmett Footman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Agoppo (Regol and Mumber or Rural Route Number, City or Town, State, Z2 1201)6 3500 Springfield Ave. Baltimore, Md. 21215 Milton Parker/Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lansdowne, Maryland Mt. Zion Cemetery 8/26/09 22. Name and Address of Facili@hatman-Harris Funeral Home 21. Signature of Funeral Service Licensee 5240 Reisterstown Rd Baltimore,MD 21215 Tans 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician ACUTE MYOCARDIAL INFARCTION <24 HOURS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an director, page 2 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only he within To the 29b. Signature and title of certifler 29d. Date signed (Month, Day, Year) 29c. License number -, MD 08-20-2009 RE3-000 30. Name of address of person who completed cause of death (Item 23a) (Type, Print) 2401 W. Belveden MD SINAI MOSPITAL OF BALTIMORE MARTIN KUBIN 32 Registrar's Signature 31. Date filed (Month, Day, Year) -State AUG 25 2009 faces Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** August 20 2 0°6′9 Anna Mae Fringer 4:50 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sykesville Carroll Transitions Health Care 8. Date of Birth 7 (Mooth, Day 93)8 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 ☐ M 2 🖾 F 71 219-34-2340 Director Maryland Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at Carroll MD Westminster Director 1 ☐ Yes 2√ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 213 Hook Rd. 21157 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No þ Specify: Specify: white 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Homemaker 8 12 should be filed with and Mental Hygie 7 Is marked other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ardel Robertson Mabel Haines permit. Pages 1 and 2 should I Department of Health and Men Important: If item 27 Is marke ೭ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David B. Fringer Sr.-husband 213 Hook Rd. Westminster, MD 21157 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date any injury or 1

■ Burial 2 □ Cremation 3 □ Removal from State 8-24-2009 Uniontown, MD 4 Donation 5 Dother (Specify) Uniontown Cem. 22. Name and Address of Facility Fletcher Funeral Home P.A. 21. Signature of Funeral Service Licensee 1-homos V. 254 E. Main St. Westminster, MD 21157 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final fordiscascular Amerosclenhi **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of the death certificate be executed signed by the attending physician and abe detached for use as the burial-trar Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death 0 9 Unknown 9 Unknown σ. The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4. Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? s certificate has b lirector, page 2 s 24a. Was an 2 No 2 ANO 1 ☐Yes 1 ☐ Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ġ 1 ☐ Yes 2 . Ho 1 Inpatient 2 ER/Outpatient 3 DOA this Medical Certification: To after death.

I Director: After this d in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐Yes 2 ☐No 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide n 24 hours aft e Funeral Di letely filled ir Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hor To the Fune completely fi (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21157 31. Date filed (Month, Day, 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene -Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8:30 PM **Physician** Day Antoinette Frankland 08 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Square Franklin Roseda le If Under 1 Year | If Under 24 Hrs. | Baltimore 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** 1 □ M 2 1 F Months Days Hours Min. 217-22-8903 **Director** 1920 Maryland July 12, Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits items 23a or 28a-f show 1 ☐ Yes 2 No Director Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7438 Manchester Road 21222 USA Funeral rankland, Antoinette Itimore, Maryland 21215-0036 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natural" or is any injury or other traumatic event, Item Modical Evant proces. If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify Specify: White þ 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 years Sales Clerk Montgomery Ward 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Andresini Gracio Caterina ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7438 Manchester Road, Dundalk, Maryland 21222 Robert S. Frankland Jr. Son altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) August 27. 20c. Location - City or Town, State Pages . 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Memorial 2009 4 ☐ Donation 5 ☐ Other (Specify) Bel Air, Maryland 21. Signature of Funeral Service Licensee Connelly Funeral Home of Dundalk, P. A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) 10 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): sician and burial-transit be executed resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical attending pt IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the a 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ s been si should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an page 2 s autopsy certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 No After this certification funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Yes 2 No 1X Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28c 28d. Describe how injury occurred Injury at Work? 5 ☐ Pending investigation

Box 68760, P.O. Records, of Vital

To the Hospitel or Attending Physician: Division death. hours after within 24 hours a To the Funeral D

Il Director: /

filled in by

Medical

State Registrar 1 Natural

2 Accident

4 Homicide

29b. Signature and title

3 Suicide

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

29d. Date signed (Month. Dav. Year) 2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Kapril Simlote 9000 Franklin Square Drive, Baltimore, Maryland 21237 31. Date filed (Month, Day, Year) gistrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

6 ☐ Could not be



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year PM **Physician** 2:30 F₀X August ZOOG DOROTHY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Beltimore Hospital of Baltimore 8. Date of Birth (Month, Day, Year) 04/29/1911 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗶 F MD 216-46-1959 98 Director Usual Residence of Decedent d 2 should be filed within 72 hours after death with the Maryland thand Mental Hygiene.

27 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'm Me first Expression in the natified at 10d. Inside City Limits 10c. City, Town or Location 10a State 1 ☐ Yes 2 👿 No Director BALTIMORE BALTIMORE MD 10g. Citizen of What Country? 10e. Street and Number USA 1 SLADE AVENUE, #704 21208 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE Specify à 3 ₩ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be NEWMAN **ELLINOR** GOLDSMITH SYLVAN 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 of Health a 4 MARION DRIVE, NORTH HAVEN, CT SHIRLEY SCHOLDER / DAUGHTER item 27 other t Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important; If I any injury or once, = 5 BALTIMORE HEBREW 08/23/2009 BALTIMORE, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 1000 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final wee Physician schemic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical the as IF FEMALE: nse s 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ō in the past 12 months? Pregnant at time of death 5 ☐ Other (specify) I □Yes 2 □No P.O. ed by the detached f 9 Unknown signed k 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has t autopsy performe ere 2 No certificate 2 110 1 ☐ Yes brovascu To the Hospital or Attending Physician: After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 4 \(\text{Nursing Home} \) 5 \(\text{\text{Residence}} \) 6 \(\text{Other (Specify)} \) 2 UNO 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Certification: To Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending within 24 hours after use.....

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar 31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

32 Registrar's Signature basera

Sinal

Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1 Per Phy Rate of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Stanley Howard Fried 055 **Physician** il Cours 200 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** KANDAIISTE HESPITAL BALTI'N VONTHINEST If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 X M 2 □ F 85 04-21-1924 Director 219-16-2595 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City. Town or Location 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Nexical Examinar must be notified at MD 1 ☐Yes 2 No BALTIMORF BALTIMORE Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 1337 SUDVALE ROAD 21208 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 □Yes 2 X No Specify. 2 Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) illed within 72 h Il Hygiene. (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) BUSINESS OWNER TOYS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GOODMAN FRIED FRANKLIN NETTIE ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BERNICE FRIED/WIFE 1337 SUDVALE ROAD, BALTIMORE, MD 21208 Department of Healt Important: If item 2: any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH TFILOH CONG. 08-23-2009 | BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROTHERS, 21. Signature of Funeral Service Licensee INC. Melt 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Examiner Due to (or as a consequence of) signed by the attending physician and the detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760, The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) 1 □Yes 2 □ No P.0. 9 Unknown 23e. Did tobacco use contribute to the pause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 3 robably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Abute RENAL Failure 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Mann f Death 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier | Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

15

State Registrar St. Date filed (Month, Day, Year)

AUG 2 5 2009

31. Registrar's Signature

hur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

farles

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Thomas William Game Certificate of Death 1- For State Reg. No Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Month August 16, 2009 Physician/ 0223 hrs William Game Thomas **Medical Examiner** c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Essex 1715 Langley Road Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year | If Under 24Hrs. 7. Age (In yrs. last birthday Social Security Number 6. Sex **Funeral** WV 07/14/1965 Days Hours Min. Months 215-94-4768 44 Director 1XXM 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any 10a. State 10b. County 1 X Yes 2 No Essex Baltimore 23a or 28a-f show notified at once. MD t. Pages 1 and 2 should be filed within 72 hours after death with the Maryland timent of Health and Mental Hygiene.
rtant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21221 326 Torner Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. Armed Forces 1 X Never Married 2 Married White 2 X No Yes Yes 2 X No specify: Specify. "naturat", o d Examiner n Give Yea Divorced Widowed \$ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+ Elementary/Secondary (0-12) t: If item 27 is marked other than " other traumatic event, the Medical ! Construction Brick Layer MD 21215-0036 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Smith Elizabeth Game Archie Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 326 Torner Road, Essex, MD 21221 John Schepleng / Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) Removal from State Burial 2 XCremation 3 8/21/2009 Hanover, MD Ardent Crematory Donation 5 Other Specify ²² Name and Address of Facility
Maryland Cremation Services 21. Signature of Funeral Service Licensee Dorota Marshall Box Baltimore, MD 1413. Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Physician failure. List only one cause on each line. Death Medical a Narcotic (heroin, methadone) intoxication and cocaine Immediate Cause (Final disease taminer or condition resulting in death) Due to (or as a consequence of): use Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit AMENDED 23a, 27, 28a-f, perM, E g895 9/3/09 TT Physician/Medical X UNPENDED attending physician or use as the burial 23d. Date of delivery Box 68760 23c. If yes, outcome of pregnancy IF FEMALE: Year Day 23b. Was decedent pregnant in the Month Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown certificate has been signed by the att ector, page 2 should be detached for g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. Yes 2 No 3 Probably 4 V Unknown ð Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed' ✓ Yes 2 1 🗸 Yes 2 No 26 Place of Death (Check only one) 25. Was case referred to medical director, Division of Vital Be Other: examiner? Residence 6 Other: Scene Hospital: Nursing Home 5 DOA ER/Outpatient 3 Inpatient this 1 🗸 Yes 2 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After 27 Manner of Death Certification: unk Yes 2 X No 1 Natural n 24 hours after death.

Funeral Director: A letely filled in by the fu Pending Fd 8/16/09 Fd 2:18 pm 2 Investigation Accident 28f. Location (Street and Number of Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 3 Suicide residence Essex, 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only the and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie August 16, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Melissa Brassell, MD 31. Date filed (Month, Day, Year) State AUG Registrar

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August Physician/ 23^{Day} Рм 2009 6:20 Louisa Merryman Ridgely Hopkins Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Hospice Care Baltimore Towson 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number Age (In yrs. last birthday) **Funeral** January 22, 1946 Days Hours Country) 1 □ M 2 🛚 F Months 143-38-7798 Maryland 63 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Maryland 10b. County Baltimore 10c. City, Town or Location Hampstead within 72 hours after death with the Maryland Director 1 Tes 2 X No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. Funeral 21074 4305 Beckleysville Road 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White "natural", 3 Widowed 4 X Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'ba pinuy or other traumatic event, the Me any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) Physician's Assistant Medical 5+ Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Louisa Merryman Ridgely Kendall Salisbury Young 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Alexander Hopkins / Son 4305 Beckleysville Road, Hampstead, Maryland 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place)

John's Cemetery 1 X Burial 2 Cremation 3 Removal from State St. 108-28-2009 Glyndon, Maryland 4 Donation 5 Other (Specify) Ruck Towson Funeral Home, 21. Signature of Funeral Service Licensye 22. Name and Address of Facility 1050 York Road, Towson, Maryland 21204 lrai 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Pancolakic years disease or condition resulting in death) , Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) /sician and 3 burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death Yes signed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Depression Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Pulmonary Embolism cate has I autopsy performed?
1 Yes 2 No ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 25. Was case referred to medica Division of Vital 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Gildwist ဂ္ဂ 1 ☐ Yes 2 🗙 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury work? 1 ☐ Yes 2 ☐ No Accident 5 Pending Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

Registrar

DHMH 17 Rev 7/2009

only one)

VMarian

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) AUG 25 2009

CRNP

G701 H. Charles St

\$2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Grant

29c. License number

R149194

Towson, MD

29d. Date signed (Month, Day, Year)

200

August 24,

21204

09-06462	
Linda Harding	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

### As Facility Name (if not institution, give street and number) ### 2604 Cambridge Beltway ### 2604 Cambridge Beltway ### 27 Age (in yrs. last birthay) ### 218 = 56 = 7970 ### 10c. City, Town or Location of Death ### Dorchester 10c. City, Town or Location 10c. Ci	irthplace (State or ign country) MD 10d. Inside City Limits 1 X Yes 2 No untry? prican Indian, Black, ite s/Industry uring te, Zip Code) 20011 or Town, State
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20. Was decedent pregnant in the past 12 months? Yes 2 No 9 Unknown 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Other (Specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute	
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24a. Was an autopsy performed? 1 V Yes 2 No 1 No Signature 1 1 V Yes 2 No 25. Was case referred to medical examiner? 1 V Yes 2 No 1 No Signature 1 1 V Yes 2 No 1 No Signature 2 No 25. Was case referred to medical examiner? 1 V Yes 2 No 26. Place of Death (Check only one) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred	?
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Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainter as an experiment of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainter as and mainter as and mainter as and mainter as an experiment of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainter as an experiment of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainter as an experiment of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainter as an examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainter as an examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainter as a constant of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainter as a constant of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and the basis of examination and or investigation and on the cause of the basis of examination and or investigation.	tated. the cause(s)
O.C.M.E. AVGUST	the cause(s)
30. Name and address of person who completed cause of death (flem 23a)	the cause(s)
Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	the cause(s)
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** AUGUST 2/2/2/9 10:49AM George Carl Harrington /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Center Baltimore Towson If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days 1**⊠** M 2□ F 216-52-6082 25, 1948 61 Mar. Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Harford Abingdon 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21009 USA 748 Frans Drive by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 XYes 2 No If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Mechanic Electric Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ralph O. Harrington Alice (unk) Deaver ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary F. Harrington / Wife 748 Frans Drive, Abingdon, MD 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem! 8-25-09 Baltimore, Maryland 22 Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature 1317 Cokesbury Rd., Abingdon, MD 21009

Physician /Medical **Examiner** or Attending Physician: The law requires that the death certificate be executed

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than " any injury or other traumatic event, it is May obnes.

Funeral

Director

28a-f show

er than "natural", or items 23a or 28a-f shown the Medical Evanturer by notified at

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

sician and burial-trans attending p ed by the a sign icate has been si page 2 should b funeral director, within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Division of Vital Records, P.O. Box 68760,

	shock, or heart failure. List only one	ations wat caused the death. cause on each line.	Do not enter the mo	ode of dying, such as cardia	c or respiratory arrest,		Interval Between Onset and Death
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Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregnand 1 Live birth 2 Fetal d 4 Pregnant at time of dea 9 Unknown	eath 3 Ectopic			23d. Date of de Month	ivery Day Year
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ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		8b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	ury occurred	
Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, street, facto	ry, office	28f. Location (Street City or Town, Sta		ural Route Number,
Medical Certification: To	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	cian: To the best of my knowler: On the basis of examination and manner stated.	edge, death occurre on and/or investigation	d at the time, date and place on, in my opinion, death occ	e, and due to the cause urred at the time, date a	(s) and manner a nd place, and due	s stated. e to the cause(s)
Me	29b. Signature and title of bertifier	on M.D	2	9c. License number D24034	29d. [Sate signed (Moht	h, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

DRIVE

OSLER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7601

32. Registrar's Signature

M. D

TIMOTHY LOW,

AUG 25

31. Date filed (Month, Day, Year)

0/6/10/

TOWSON, MARYLAND 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** bara /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Baltimore City** The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗹 F Hours 215-74-1632 MARYLand **Director** 1965 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director timore 10e. Street and Number 10g. Citizen of What Country? Funeral tomac 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 Specify: If Yes, Give Year or Dates: 1 Yes 2 Ho 2 Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 1)omestic omemulceil 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Watso Johnson Lee ပ 19a. Informant's Name/Relationship (Type. Print) Wolher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21224 Department of Health Locille 10 tomac Baltimore, 20b. Place of Disposition (Name of eemetery, crematory or other place) 20a. Method of Disposition 20c. Location 1- Burial Cremation 3 Removal from State Injury or Important: If -09 BOUTO 4 Dop 21. Signate art 1. Enter he disea shock, or heart failure. or complications that caused the death. Do not ente List only one cause on each line. the mode of dying, such as cardiac or respirato Approximate interval Between Onset and Death Immediate Cause (Final astatestical **Physician** bleed disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Alcoholisa Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) by the attending physician and etached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical 68760 IF FEMALE: Box (23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetal death Day in the past 12 months? Year Pregnant at time of death 5 Other (specify) Yes 2 No P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed 2 Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has 2 No certificate 1 Tyes Vital To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 2 No 1 Inpatient 1 Tyes 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) ဂ္ Division of After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deat Funeral Director: 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 - Homicide City or Town, State) 29a. Certifier Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) August 17, 2009 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) bert 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) 82. Registrar's Signature State AUG 25 2000 Registrar back

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician Jugost :15 AM aster tress 2009 /Medical 4c. County of Death or Location of Death acility Name (If not institution, give street and number) Examiner Baltimore are ANOR If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year. Days Min 1 □ M 2 0 F IRGINIA -520 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any hujury or other traumatic event, it is healthe 23 in any injury or other traumatic event, its health. 1 Yes 2 No Director Baltimore Ma 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2525 Quanter 21 213 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify BLacia þ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Homemaker Elementary/Secondary (0-12) College (1-4or 5+) omestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (000de GRACIE shton Davis 19a Informant's Name/Relationship (Type. Print) Daughter 19b. Mailing Address (Street and Number or Ryral Route Number, City or Town, State, Zip Code) Call La Woshington Md 433 Rancine Speicson 10095 20a. Methed of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 1 Burial Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MINGE'S THE HE POLITURE 21. Signature of Funeral Service Licensee Breadway Approximate Interval Between Onset and Death 23a. art 1. Enter the disease, or complications that caused the shock, or he fit failure. List only one cause on each line. pplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory rrest, Invediate Caure (Final disease or condition resulting in death) **Physician** , /Medical Due to (or as a conseque ce of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? Month 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Onknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 🗆 Yes 1 ☐ Yes 2 1 No 25. Was case referred to medical 26. Place of Death Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred ospital or Attending hours after death. 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 🗆 No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ò 4 Homicide To the Hospital 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 90 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ham Woods Ron

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

Darke

Registrar's Signature

09-06450 William Jacobs

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

iam Jacobs		State of Maryland / Department of Health and Mental Hy -For State Certificate of Death	giene	Reg. N	lo.	200	19 2709
		Registrar	2. Date o	f Death			3. Time of Death
Physicia	1117	1. Decedent's Name (First, Middle,Last)	Month Augus	Da st 18, 20	909	Year	0313 hrs
dical Examir		William Jacobs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	7.09			nty of Death	
		University Hospital Baltimore			Ba	1+imor	ce City
		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.	. 8. Date	of Birth(N	M/DD/Y	YYY) 9. Birti	hplace (State or
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th wit	Funeral	Armed Forces? If Yes, specify Cuban, Mexican, Puerto	Rican, et	tc.)	'	White, etc.	
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36 in 72 han dical	ple	Manak Driver] .	Tran	sporta	ation
with giene	E	12 TITUCK DITVET 17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, M	liddle, Mai	den Surr	name)	
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212 ould be Ment mark	.0 B	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or I	Rural Ro	ute Numbe	er, City or	r Town, State	e, Zip Code)
D sho	۲	William S. Jacobs / Father 211 Glen Rd.; Glen F		ie, M	D 2	1060	7 00-1-
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Fleath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-5 sho injury or other traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) A110	Date 7. 21		20c. Loca	ition - City of	r Town, State
DOF ages 1 at of 1 other		1 X Burial 2 Cremation 3 Removal from State	200		31km	idae.	Maryland
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		The de We know The mall	- O INIE				
-		30. Name and address of person who completed cause of beath (Item/23a) Theodore M. King, Jr. MD. Assistant Medical Examiner 111 Penn Street, Baltim	ore Mi	D 21201			
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			For	State of Maryland				Mental Hyg	iene		
			State Registrar		Cei	tificate of	Death		eg. No.	2000	0 7 0 0
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	/Medic		Melzetta Jack					August		2009	8:43A
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Galti permit.	mpo iny ir		21. Signature of Funeral Service Licer	isee		2. Name and Addre	M	arzullo	Fun	eral	Chapel, I
	_ 10 O		Michael F. Ma	rzullo						Mary,	land2121
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DIN To the Hospital or		O	29a. Certifier 1 XCertifying P	hysician: To the best of my kno	wledge, dea	th occurred at the t	time, date and pla	ce, and due to the	cause(s)	and manner as	s stated.
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ı	Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	Day Ye	3. Time of Death
-	/Medic Examin	al	Joseph 4a. Facility Name (If not institution, give street and number)	Kremer	4b. City. Town, or	r Location of Death	August	22, 2009 4c. County of D	6:35 p M
ne de	Examini	ei	Presbyterian Home		Towso			Balti	more
	Funeral Director		5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da December	y, Year)	Birthplace (State or Foreign Country) anyland
	and ow		Usual Residence of Decedent 10a. State 10b. County 10	Oc. City, Town or Loc	cation				10d. Inside City Limits
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	h with the 23a or 28	al Director	10e. Street and Number 6712 Duluth Avenue		10f. Zip Code 21	222		10g. Citizen of What	Country?
36	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, I'm Madical Examinant in Italian at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Yes, Give	I .	Was Decedent of H f Yes, specify Cuba I □Yes 2 No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		merican Indian, /hite, etc. White
Maryland 21215-0036	n 72 hour	Completed b	3 → Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	(Give I	ient's Usual Occup kind of work done o	during most of worki	ng	16b. Kind of Busine	
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	and 2 s ealth ar n 27 ls ner trau		Ted G. Kremer Nephew					wn, Maryl	
Baltimore,	es 1 of H fiter		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispos cemetery, crem Sacred Hears	sition (Name of natory or other place t of Jesus	Cem. Augus 200	ž 26,	20c. Location - City Dundalk ,	
Balt	permit. Pag Department Important: I any Injury o once.		21. Signature of Funeral Service Licensee	Cly 7	Name and Address Onnelly 7 110 Solle	s of Facility Uneral Ho ers Point	me O£ [Road, [Oundalk, P. Oundalk, Ma	A. Layland 21222
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P.O. Box	The law requires that the death certifinate has been signed by the attending I bage 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of 1 □ Live birth 2 □ 1 □ Live birth 2 □ 1 □ Pregnant at tin 9 □ Unknown	Fetal death 3	Ectopic pregnanc Other (s <i>pecify)</i> _	у		23d. Date of Month	delivery Day Year
	w requires that s been signed b should be deta	þ	Part II. Other significant conditions contributing to death but no a cute renil follows	not resulting in the un		en in Part I.	23e. Did to		te to the cause of death? Probably 4 🗆 Unknown
Records,	The law rec ate has bee bage 2 shou	Completed						osy prior rmed? deat	e autopsy findings available to completion of cause of h? Yes 2 1940
Vital		Be C	25. Was case referred to medical examiner?		Tou	26. Place of Death			
	Physi rthis ral dir	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 27. Manner of Death 28a. Date of Injury	2 ER/Outpatien		4 Lar Nursing Ho		dence 6 Other (Specify)
on	nding F th. :: After e funera	ation	1 Mainty 1 Matural 5 Pending (Month, Day, You 2 Accident investigation		Wor	k? Yes 2 □ No	Lou. Describe	low injury occurred	
Division of	al or Attending Physiclan: s after death. I Director: After this certific id in by the funeral director, i	Certification:	a Cleviside 6 Could not be	- At home, farm, stre (Specify)	eet, factory, office		28f. Location (\$ City or Tov		r Rural Route Number,
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	Medical (29a. Certifier (Check only one) 1	xamination and/or inv					
À	To ti withi To ti	Š	29b. Signature and title of pertifier (%)	1.	29c. Licens	37016		29d. Date signed (M	Jonth, Day, Year)
	20 v		30. Name and address of person who completed cause of deat Kenuth M. (ree w. mo 67 31. Date filed (Month, Day, Year) 32. Segistrars	h (Item 23a) (Type, I	Print) les St, S	Tank 4104	, 13.1	Laure, "	Losiz an
	Sta Registr		31. Date filed (Month, Day, Year) AUG 25 2009 32. Segistrars	Signature	and				

			For State	State of	Marylan									
			Registrar			Cei	rtificat	e of L	Jeath			Reg. No.	COLL	105-10-1
	Physicia /Medic		1. Decedent's Name (First, Mide	Keile Keile							2. Date of Dea	Day	19 Year	3. Time of Death 1
in a	Examin		4a. Facility Name (Harot instituti	on, give street and num	nber)			11.7	Location			4c. (County of Deat	h
	Funeral		5. Social Security Number	6. Sex 1 □ M 2 □ F	7. Age (In yrs. I	last birthday) Yrs.	If Under Months		If Under Hours)	8. Date of Bir (Month, Da	y, Year)	9. Birt Co	hplace (State or Foreign untry)
	Director		218–44–7265 Usual Residence of Decedent	. X		Trs.					11/9/1	945	Mar	yland
	yland how		10a. State 10b. Count	у	10c. City	y, Town or Lo	cation							10d. Inside City Limits
	e Mar 3a-f sl	ctor	MD Balt	imore	Ca	tonsvi	ille							1 □Yes 2 No
	/ith th	Dire	10e. Street and Number				10f. Zip		1 000			-	zen of What Co	untry?
	death with the Maryland ims 23a or 28a-f show ir must be notified at	Funeral Director	55 Wade Avenue		dent Ever in U.S	S 13	Was Decer		1 228 ispanic Or	igin? (Spe	cify Yes or No		SA 14. Race - Ame	rican Indian.
36	it e	þ	11. Marital Status1 ☐ Never Married 2 ☑ Ma3 ☐ Widowed 4 ☐ Divorce	Armed For urried 1 ☐ Yes If Yes, Giv	rces? 2 XNo re		lf Yes, spec 1 ∐Yes		n, Mexical		cify Yes or No Rican, etc.)		Black, White	
Maryland 21215-0036	e filed within 72 hours aft al Hygiene. other than "natural", or vent, the Medical Exami	Completed	15. Decede (Specify only high	ent's Education est grade completed)		(Give	dent's Usua kind of wor	rk done c	during mos	st of workin	ng	16b. Kin	nd of Business/	Industry
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d 2	il Hyg other	Be C	17. Father's Name (First, Middle				V			_	(First, Middle,			ELM
ylar	2 should be f n and Mental is marked o raumatic eve	To E	Ellsworth M. K	Keirle, Sr.					Do	ris I	Daniels			
Mar	ges 1 and 2 should it of Health and Mer If item 27 is marke or other traumatic		19a. Informant's Name/Relation Brenda Keirle			1	•	•				-	Town, State, 2	
	es 1 and 2 of Health a f item 27 is ir other tra		20a. Method of Disposition	/ spouse	20b. P	Place of Dispo	**				ate Ma		nd 2122 cation - City or	
E O	Pages nent of int: If it	- 4	1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other			idowric				8/24/	2009	Elkı	ridge,	Maryland
Baltimore,	permit. Pages Department of Important: If ii any injury or once.		21. Signatule of Funeral Service	e Ligensee	1								al Home	•
ш	40 5 6 0			Lund									e, Mary	rland 21229
		E 17	23a. Part 1. Enter the disease, shock, or heart fallure. List Immediate Cause (Final	or complications that c st only one cause on e	ach line.	n. Do not en	er the mod	e or dyin	JZ A	s cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	aDue to	o as a consegu	uence on:	he_	2116	ine					
N S	Examiner		Sequentially list conditions,	b	aorti	ic d	isse	cti	00					
1	ed sit	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	uence of):								
, 6°C	cate be executed bhysician and the burial-transit	Examine	that initiated events resulting in death) Last	c	or as a consequ	uence of):								
8760	ysicia ne buri	dical		d										
9	ertifica ling ph		IF FEMALE:	1-2-37										
Вох	requires that the death certific een signed by the attending p nould be detached for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live I	come of pregna pirth 2□Feta nant at time of d	I death 3	☐ Ectopic p		у			2	23d. Date of de Month	livery Day Year
0	the de	nysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unkn		Jean 51		7601Y/						
s, P.	gned k		Part II. Other significant condi	tions contributing to de	eath but not resu	ulting in the u	nderlying c	ause giv	en in Part	l.	23e. Did t			the cause of death?
ord	een si nould b	ted	·					_			1 🗆	Yes 25	VINo 3□P	robably 4 Unknown
Division of Vital Records,	aw as b 2 sł	Completed by									24a. Was auto	osv /	prior to	utopsy findings available completion of cause of
Ta I	ifficate or, pag		25. Was case referred to medic	al					26 Plac	o of Dooth	1 ☐ Yes (Check only o	2 No	1 □ Yes	s 2 1 No
N N	Physician: r this certific ral director,	o Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	npatient 2 🗆	ER/Outpatie	nt 3 🗆 D0	DA Oth	or.				3 □Other (Spe	ecify)
n o	e te	on: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pend	28a. Date (Mon	of Injury th, Day, Year)	28b. Time o Injury		28c. Injur Work	y at	- 2	28d. Describe	how injury	y occurred	
Sio	Attending or death. ector; After by the fune	catio	2 Accident inves	stigation			M		Yes 2□		205 1	0	111 t D	D. to March a
ΟĬ	after of Direct of Jin by	Certification: To	4 ☐ Homicide deter	mined 20e. Place buildi	of Injury - At hong, etc. (Specif	y)	eet, lactory	y, Office		l'	City or To	wn, State))	ural Route Number,
	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completely filled in by the fur	Medical C		ring Physician: To the										
	To the within To the comple	Mec	29b. Signature and title of certif	_/_//	o.atou.		290	c. Licens	e number			29d. Date	e signed (Mohi	th, Day, Year)
	- 0		1	//				70	15-	52		8	119/0	19
	10		30. Name and address of person	on who completed caus	e of death (Item 2-2 egistrar's Signa	n 23a) (Type,	Print)	1	51.	Su	ite 12	D-5	5 Ralli	more MD 2122
8	Sta	te	31. Date filed (Month, Day, Yea	r) 32. F	egistrar's Signa	ature	1	t	(*				1001111	1000
	Registr	ar	AUG 25 20	109 Chen	D. 1	gave								

Anais Kasten-Sportes State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month **Medical Examiner** Anais Virginia Kasten-Sportes 1755 hrs August 18, 2009 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** oreign Director Months Days Hours 216-27-4125 July27,1986 1 M 2X F 23 Country) Michigah Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No 28a-f show Maryland Montgomery remit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
mportant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Potomac Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 9312 Garden Court 20854 U.S.A. 11. Marital Status . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Black, 1 XNever Married 2 Married Armed Forces? White, etc. 2 X No Yes 3 Widowed If Yes, Give Year 1 Yes 2 X No specify: Specify: White ⋧ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry ment of Heath and Mental Hygiene.
fant: If item 27 is marked other than "natur
or other traumatic event, the Medical Exam Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 Student College 3 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Claude Sportes Carol Kasten 19a. Informant's Name/Relationship (Type, Print.) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Kasten/Mother 9312Garden Court, Potomac, Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State Baltimore, crematory or other place) y Burial 2 ☐ Cremation 3 ☐ Removal from State Brighton, Michigan Fairview Cemetery 8-25-09 Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P. A Road, Baltimore, Maryland21214 6009Harford 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Approximate Interval Between Onset and /Medical Death a Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and Physician/Medical the attending physician red for use as the burial -UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Fetal death Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed this certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed' ✓ Yes 2 No 1 🗸 Yes 2 No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Be Other4 Hospital: 1 Inpatient 2 🗸 ER/Outpatient 3 Nursing Home 5 Residence 6 Other 1 🗸 Yes 28a. Date of Injury FOUND: After 1 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject jumped from apartment building Natural FOUND: 1 Yes 2 ✔ No Director: Pendina Aug 18, 2009 1724 hrs Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 11750 Old Georgetown Rd, Rockville, MD determined (Specify) Multi-Family Apt To the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E. August 19, 2009 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

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Registra

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		ı	State of Maryland / Dep. State of Maryland / Dep. Registrar Ce	artment of Health and N ertificate of Death		ene g. No. O O O O O O O O O O					
1	Physician		1. Decedent's Name (First, Middle, Last) Agatha E. L'Altrelli		2. Date of Death August 22, 2009 9:15 P M						
	/Medic	al	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	August	4c. County of Death					
1			Stella Maris 5. Social Security Number	Timonium If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Baltimore 9. Birthplace (State or Foreign					
	Funeral Director		233-34-2218 1□ M 2√x F 86 Yrs.	Months Days Hours Min.	Aug 12,	1923 West Virginia					
_	/land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L			10d. Inside City Limits					
	Ba-fsk	al Director	MD Baltimore Luthervi			1 ☐ Yes 2 🖾 No					
	3a or 2		10e. Street and Number 248 Cinder Road	10f. Zip Code 21093		USA					
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "hodical Eventians ritual by notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 13. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 14. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 5 Married 15. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 5 Married 6 Married 7 Married 7 Married 7 Married 7 Married 7 Married 8 Married 7 Married 8 Married 9 Married	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White					
5-00	72 hou 'natura dieni E		15. Decedent's Education (Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	ing	16b. Kind of Business/Industry					
2121	d within giene. ir than '	Completed	Flementary/Secondary (0-12) College (1-4or 5+)	emaker		Own Home					
pue	be filed ntal Hyged othe event,	Be	17. Father's Name (First, Middle, Last) Rollie Miller	18. Mother's Nam Anna Mat	e (First, Middle, N hews	flaiden Surname)					
$^{\circ}$. $^{\it M}$. Marvland 21215-0036	2 should and Mer is marke raumatic	인	19a. Informant's Name/Relationship (Type. Print)	ling Address (Street and Number or Ru	ral Route Number,						
P.M	1 and 2 Health sm 27 i			Cinder Road Luthe		Maryland 21093 20c. Location - City or Town, State					
9:15 F	Pages nent of ant: If its ary or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	osition (Name of ematory or other place) Cemetery 8/29/		Baltimore, Maryland					
9	permit. Departi Importa any inju					ryland 21204 Inc. 1050 York Road					
(Physician /Medical Examiner	er	Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								
22, 2009 68760	ificate be executed g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):								
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TRELLI Vital Records	Attending Physician: The law rest death. st death. by the funeral director, page 2 sho	Completed				prior to completion of cause of death? 2 ⊠No 1 □ Yes 2 □ No					
LALTRELLI	ysiciar is certif	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ Vo Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient		th <i>(Check only on</i> lome 5 ☐ Reside	e) ence 6 □Other (Specify)					
_ 5	Ming Ph n. After th funeral	lon: 1	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 28a. Date of Injury 28b. Time of Injury Work? 1 Natural 5 Pending (Month, Day, Year) M 1 Yes 2 No								
AGATHA J	= E f f o	Certification: To	2 Accident 1 Yes 2 No 2 Accident 3 Suicide 4 Homicide 28t. Location (Street and Number or Rural Route Number of Rural Ro								
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	To the within the total company of the	M	29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Month, Day, Year)					
	65		30. Name d ss of p rson who completed cause of death (item 23a) (Type MARIAM BAKIR, CRNP 2300 DULANEY VAI		M, MD 21	093					
	Sta Registi										

DHMH 17 Rev 1/2001

For		se Type or Pri			artment of H	lealth and N	Jental Hyd	iene				
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H. Elain	ie Lapour	raille					08-16-20	009 ^{ay}	Year	0600 4		
	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County											
		e Medical (Center	r		Air			rfor			
5. Social Security I 219-22-(0540	6. Sex 7. A 1 □ M 2 💢 F	ge (In yrs. i	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 1 Month Day 07-23-1	927				
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521 Wood 11. Marital Status 1 Never Mar	IDULY Wa	12. Was Deceden		S. 13.	Was Decedent of H	lispanic Origin? (Sp	pecify Yes or No-	14. Race				
	ried 2 X Marrie			If Yes, specify Cuban, Mexican, Puerto Ricán, etc.) Black, 1						etc.		
	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:				1 □Yes 2🌠 No	Specify:		Specify.	Wh:	ite		
(Spe	15. Decedent's	Education			dent's Usual Occup			16b. Kind of Bu	siness/Ir	ndustry		
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-	. Fisher											
19a. Informant's N				1	•			-	State, Zi	ip Code)		
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20a. Method of Dis 1 X Burial 2		3 ☐ Removal from State)		osition (Name of matory or other place				•			
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21. Signature of F	uneral Service Li	icansed	\bigcirc									
1	Inc. 610 W. MacPhail Rd Bel Air, MD 21014											
shock, or he	shock, or heart failure. List only one cause on each line.											
Immediate Cause (Final disease or condition resulting in death) Execute magnetic Dissociation												
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Sequentially list co	Sequentially list conditions, if any, learning to himiculate cause. Enter Underlying Cause (Disease or injury											
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Vear **Physician** AM phalbo :15 00150 August 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 1506 West Joppa Road Towson Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 T F Months Days Hours Min. 95 **Director** Aug. 14, 1914 New York 063-18-4236 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show if than "natural", or items 23a or 28a-f show the Medical Examinating the notified at 1 ☐Yes 2√No Director Towson Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1506 West Joppa Road 21204 S.A. by Funeral permit. Pages 1 and 2 should be filed within 72 hours after dear Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or itemany injury or other traumatic events. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Specify. Specify: White 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Cook/Manager 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Luigi Lanzi Amalia Marotta ၀ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise Amalia LoBalbo Philipp 1506West Joppa Road, Towson, Maryland21204 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bayview Crematory 8-22-09 Baltimore, Maryland 21. Signature of Funeral Service Licensee

Included P. Marguello 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 6009Harford Road, Baltimore, Maryland21214 23a. Part1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) days **Physician** /Medical Due to (or as a consequence of): etastatic Examiner - Unknown Se uentiall, list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-tran and Due to (or as a consequence of): the attending physician hed for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown certificate has been signed by rector, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 □ Yes 2 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an 1 ☐ Yes 2 ☑ No or Attending Physician; funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl. one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 □Yes 2 □No 2 Accident **Director**: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

To the Hospital o within 24 hours af To the Funeral Di

State

29b. Signature and title of certifier

Xander

MA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

29c. License number

29d. Date signed (Month, Day, Year)

GLORIA MCINTOSH

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P. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation		28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred					
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29c. License number

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

nours after death neral Director: / filled in by the f

within 24 hours a

To the Funeral C

30. Name and person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Medical

29b. Signature and

2300 DULANEY VALLEY RD. JACKIE JONES, 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2ŎÖ9 **Physician** a^{M} 5:55 August Ella L. McDade /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Baltimore Morningside House of Satyr Hill 8. Date of Birth (Month, Day, Year) Jan 6, 1909 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours 1 □ M 2 € F Months Virginia 100 229-10-6929 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, he Medical Exprints must be neitlind at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 □Yes 2X No Director Baltimore Baltimore Md. 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number USA 21234 8800 Old Harford Rd. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White etc. 1 ☐ Yes 2**X** If Yes, Give Year or Dates: 1 Never Married 2 Married 2**X** No Baltimore, Maryland 21215-0036 1 □Yes 2/□No White Specify Specify: Completed by 3 Widowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Atlantic Ice Bookkeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eugene Wadworth Lipscomb Mable Crooks ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1716 Windy Hill Rd. Lancaster, Pa. 17602 Mrs. Ella Marie Hull/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State permit. Page: Department o Important: If i any Injury or Hilltop Service Co. 8-25-09 Towson, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune A Service Licer 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 0,50950 oschrouascular Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Hibrill otion Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events quenes of; Examiner Hyper tension The law requires that the death certificate be executed for use as the burial-tran and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician ession)epr Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day 5 Other (specify) ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate I 1 □Yes or Attending Physician: : After this certification of the funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation hours after death. filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type Print) 7602 Below Rd; Bothmare, MD 31. Date filed (Month, Day, Year) AUG 25 2009 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2:05 P M 23 Physician 2009 Keith Howard August /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Pasadena 193 Circle Road 8. Date of Birth (Month, Day, Year 3/18/1947 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min. California 1 X M 2 □ F 526-78-5493 62 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State from marked other than "natural", or items 23a or 28a-f shov traumatic event, the Marked Examiner must be notified at 1K Yes 2 No Director Anne Arundel Pasadena MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21122 U.S.A. 193 Circle Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Mayes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2K Married 1 ☐ Yes 2 🛛 No Specify. White Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Aircraft/ Ships Technical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marilyn Kay Chute Charles Henry ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 s ment of Health an ant; If item 27 is Circle Road Pasadena, MD 21122 permit. Pages 1 and : Department of Health Important: If item 27 any Injury or other tra Donna Munn/ Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/24/2009 Hanover, Maryland Anatomy Gifts Registry 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licenses 7522 Connelley Dr., Ste.P, Hanover, MD 21076 auna 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Canco siagiatie MUNTHI **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tran Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) detached 9 Unknown After this certificate has been signed by funeral director, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Tes 2 Mo 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑No 24a. Was an autopsy 1 ☐Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Physician: The or Attending within 24 hours after death.

To the Funeral Director; A completely filled in by the fu To the Hospital

Baltimore, Maryland 21215-0036

State

29a. Certifier (Check only

29b. Signature and title of certifier

Registrar

DHMH 17 Rev 1/2001

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and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

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7	To the Hospital or	within 24 hours afte	To the Funeral Dire	completely filled in	
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		For State Registrar					Cei	tificate of	Death		Reg. No.	2009	27/05		
Physicia		1. Decedent's Nam SYLVIA	ne (First, Middl		ORGAN						ath Day,	2009 Year	3. Time of Death 4:30A M		
/Medic		4a. Facility Name (-)		4b. City, Town, or Location of Death UPPER MARLBORO				County of Deat			
Funeral Director		5. Social Security 1	Number	6. Sex 1 □ M 2	7. Ac	ge (In yrs. i	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24		rth ay, Year) 20 1	The Co	hplace (State or Foreign unitry)		
and		Usual Residence o	of Decedent 10b. County			10c. Cit	y, Town or Lo	cation		DILLE	20 1	7.70	10d. Inside City Limits		
e Maryi la-f sho	ctor	MD PRINCE GEORGE					ER MAR	LBORO			1 🖂 Yes				
with the	Dire	10e. Street and Number 12619 CAMBLETON DRIVE						10f. Zip Code 20774				zen of What Co	untry?		
filed within 72 hours after death with the Maryland filed within 72 hours after death with than "natural", or items 23a or 28a-f show ont, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☐ Married 12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ☐ No 1 □ Yes 2 ☐ No 1 □ Yes 3 ☐ Ye								? (Specify Yes or Notuerto Rican, etc.)	0-	14. Race - Ame Black, White Specify: BL	e, etc.		
thin 72 hour le. lan "natural"	Completed t	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)						dent's Usual Occup kind of work done DO NOT use retire	during most of	working	16b. Kir	nd of Business/			
d d d	To Be Cor							l	Name (First, Middle ROBINSON	, Maiden	Surname)				
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t. Pages 1 and 2 rtment of Health a rtant; If item 27 is njury or other tra		4 Donation	ÖCremation 5 ☐ Other (S	(pecify)	I from State		EDDVIE	sition (Name of natory or other pla CREMATO	_{DV} 8,	Date /20/2009 B JENKINS	D T 17 E1	cation - City or	MD		
permi Depar Impo any ir		21. Signature of F	uneral Service	Licensee -/10/	1/		7	2. Name and Addre	OVER RD	LANDOVER	, MD	20785			
Physician /Medical Examiner in and properties (ial-transit	Examiner	23a. Part1. Enter shock, or he Immediate Cause disease or condition resulting in death) Sequentially list or if any, leading to incause. Enter Und Cause (Disease of that initiated event	ert fair re. List (Final ion) onditions, mmediate lerlying	a. b.	se on each li	ine.				rdiac or respiratory mia istatic hage	arrest,		Approximate Interval Between Onset and Death		
be icia		resulting in death)	Last	d	Due to (or as	a consequ	uence of):	• •		0					
The law requires that the death certificate bate has been signed by the attending physic page 2 should be detached for use as the bi	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown								2	23d. Date of de Month	livery Day Year			
res th	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								tobacco u Yes 2[o the cause of death?			
n: The law re ificate has be or, page 2 sho	Completed	QE Was ages refer	arrad to madica							1 □ Yes	opsy ormed? 2 □ No	24b. Were as prior to death?	utopsy findings available completion of cause of		
hysicla nis certi i directo	To Be	25. Was case refe examiner? 1 ☐ Yes 2 ☐		Hospita	l: 1	ient 2 🗆	ER/Outpatier	nt 3 □ DOA Oth	nor:	Death (Check only ing Home 5 🖾 Res		6 □Other (Spe	ecify)		
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification: To	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 1 Sec. Injury at Work? M 1 Yes 2 No 28d. Describe how injury occurred Work? M 1 Yes 2 No 28d. Describe how injury occurred Work? M 28d. Describe how injury occurred							ural Route Number,						
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical C	29a. Certifier (Check only one)		Examiner: O	n the basis	of examina				place, and due to th occurred at the time					
To the within To the comple	Mec	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 08 / 19 / 0 9									th, Day, Year)				
		30. Name and add	Perm	anen	te,1	221	n 23a) (Type,	Print) and ile	Las	ne lar	50 1	140 2	20774		
Stat Registra		31. Date filed (Mo.	G 25 21		82. Regist	rar's Signa	sture Land	الم			/				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1 Year Day Physician 1820 M Victoria Len Mahoney 200 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Randallstown Season's Hospice | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Feb. 27, 1 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 ⋤ F Maryland 1967 42 220-76-5146 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or ttems 23a or 28a-f show any or other traumatic event, the Medical Examinat must but retitled at 1 ☐Yes 2√ No Director Windsor Mill MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21244 7107 Chamberlain Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Never Married 2 ☐ Married Specify: White Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. If Yes, Give Year or Dates 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nancy Lee Diggs Robert H. Kurtz, Sr. ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1210 Summerwood Court, Arnold, MD 21012 Robin Kaluzienski - Sister Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition West Arundel 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page: Department o Important: If any Injury or 8-20-2009 Odenton, MD 22. Name and Address of Facility Ambrose Funeral Home, Inc. uneral Service Licenses 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** TERMINAZ LUNG CANCER /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an certificate has t irector, page 2 sl autopsy performed? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 ROther (Specify) Hospice 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 5400 Old Court Road Randalls town 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gbrmah DWIM

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

Deneura

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Ruby E. McDonald August 12 2009 ar 9:03 P. M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 4303 Royal Avenue Hampstead Carroll | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Dec. | Month | Day, Year | 1921 9. Birthplace (State or Foreign . Social Security Number 214–22–3843 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M **XX**F 87 Yrs. Virginia Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Exeminer must be notified at Director 1 ☐ Yes 🙀 No Maryland Carroll Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4303 Royal Avenue 21074 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2X No Specify. White Š Specify: 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Jarvis Bertie Chrissman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philip J. McDonald Son 4303 Royal Avenue, Hampstead, Maryland 21074 permit. Pages 1 and : Department of Health Important: If item 27 any Injury or other tr: once. 20a. Method of Disposition

1 → Hermonia | 2 → Cremation | 3 → Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Woodlawn Cemetery 8/17/2009 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21. Signature of Funeral Service 3631 Falls Road, Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cancer 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Ves 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ⊠Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident illed in by the f 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral [29a. Certifier 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D003809 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. Linda Olding 4231 Northwoods Trail Hampstead, Maryland Hampstead, MD 21074 State Deneur

Registrar

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division of Vital Records,

Baltimore, Maryland 21215-0036

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Box 68760 P.0. Division of Vital Records,

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 1240 PM MCKENNA AUG 2000 HELEN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner AIG of MARILAND HEDICAL center BAUTHORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/28/1919 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Hours Months Days 1 □ M 2 🔀 F 90 Pennsýlvania Director 153-01-4916 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b Counts 28a-f show injury or other traumatic event, the Medical Examiner must be nuffilled at 1 ☐ Yes 2X No Director Sykesville Carroll MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 21784 United States 1115 Buckhorn Road items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Black White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐Yes 2 1 □ Never Married 2 □ Married ò 1 ☐ Yes 2 No White Specify: 2 3 X Widowed 4 ☐ Divorced Year or Dates "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Assembly Manufacturer Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be th and Mental F Nellie Farrel Charles Flemming ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau 1115 Buckhorn Road, Sykesville, Maryland 21784 Helen Supplee (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Deurial 2 Cremation 3 Removal from State St. Mary's Cemetery 8/24/2009 Williamstown, NJ 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RENA FAILURE disease or condition resulting in death) Due to (or as a consequence of) CYAO S THEOHBUCHTOPENIC THROMBOTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physi IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 | Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 No 1 ☐Yes 2 ☐No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 □Yes 2 □ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier AU4176435 M1977a 2009 Merron 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BACTHORE, MD 21201 22 SOUTH GREENE MEHKOTEA Steret 31. Date filed (Month, Day, Year) 32. Registrar's Signature State UG 25 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Physici		1. Decedent's Name			21100	. ^				2. Date of De Month	Day	Year	3. Time of Death	М
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Examin	er		-	ve street and number)		4b. City, Town,	TIMOR			40.00	N/A		
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r Atte er de recto	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not determine	20e. Flace UI	njury - At ho etc. (Specify	me, farm, s	treet, factory, office	Э		28f. Location City or To	(Street and own, State)	Number or Rur	al Route Number,	
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one)		Physician: To the be aminer: On the basis and manner	of examinat									
Fo the within To the comple	Mec	29b. Signature and	d title of certifier				29c. Licer	nse number				signed (Month,		
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		30. Name and add	lress of person wh	o completed cause o	f death (Item	23a) (Type	e, Print) LEVI	NDA	LE	AU	ANC	ASNI	tui	
		2434 4	BELVE	FRDERE 32. Fegi	AVE	BA	LTIMORI	G 1	ND					
ິ Sta Regist		31. Date filed (Moi	ntn, Day, Year)	32. regi	strar's Signal	D. 4	arked							
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)5587		Please Type or I	Print in Black Ind	lelible In	ik. Ensure A	II Copies	Are Legib	le.	
Mar	ia Parker Na		State of - For State	Maryland / Depar	tment of ificate of	Health and M Death	ientai riygi		200	9 2711
	Dhurisi	F	Registrar 1. Decedent's Name (First, Middle,Last)	OCITI	noute or	Douth		Reg. Note of Death		3. Time of Death
Me	Physicia dical Exami	11/4	Maria Parker	Nasir			J	Nonth Da Uly 17, 2009		0409 hrs
			4a. Facility Name (if not institution, give str		4	b. City, Town, or Loca			4c. County of Death	
			Fort Washington Hospital			Fort Washingto			Prince George'	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	t birthday)		tours Min.			washingto
	Director	ļ	577-76-7123 1 M	2 XF 54	Yrs.			July 7	,1955 Cou	ntry) DC
	ý	- [Usual Residence of Decedent 10a. State 10b. County	10c. City. 7	own or Locati	on				10d. Inside City Limits
_	ow any	- 1	,							1 X Yes 2 No
	vith the Maryland s 23a or 28a-f show a e notified at once.	Director	DC 10e. Street and Number	wa	shing	10f. Zip Code		10g.	Citizen of What Coun	iry?
٠	e Mai or 28 Feda	ie	2647 30th Street	- S.E.		200	20		USA	
	vith th s 23a e noti			2. Was Decedent Ever in U.S	i. 13. Wa	s Decedent of Hispani	ic Origin? (Speci	fy Yes or No-	14. Race - Americ	an Indian, Black,
	eath v item	Funeral	1 Never Married 2 X Married	Armed Forces? Yes 2 X No	lf Y	es, specify Cuban, Me	exican, Puerto Ric	an, etc.)	White, etc.	
	fter d	by Fi	3 Widowed 4 Divorced If y			Yes 2 X No sp				ack
	ours a	象	15. Decedent's Education (Specify only	nighest grade completed)	16a. Deceder during m	nt's Usual Occupation (lost of working life. DO	(Give kind of work NOT use retired)		b. Kind of Business/Ir	ndustry
	6 n 72 h isan "r	ompleted	Elementary/Secondary (0-12)	College (1-4 or 5+)					Drivato	Industry
	21215-0036 uld be filed within 7 Mental Hygiene. marked other than r event, the Medica	E	10th 17. Father's Name (First, Middle, Last)		Food	Service	Mother's Name (Fi	rst, Middle, Maid		
	filed all Hyg	Be	· · · · · · · · · · · · · · · · · · ·	arker			Clara	Beall		
	212 uld be Ment mark c ever	To B	19a. Informant's Name/Relationship (Type	e, Print)						Zip Code 20748
	MD d 2 sho lth and n 27 is aumati		Patricia R. Par	ker/Daughte	+ 310	3 Good H	ope RD	#102,5	Temple H	lls,MD
	G, F I and Healt Fitem		20a. Method of Disposition 1 Burial 2 X Cremation 3		lace of Dispos rematory or ot	sition (Name of cemete ther place)	ery, C	ate 2	0c. Location - City or	Town, State
	Pages ent of nt: I		4 Donation 5 Other Specify:	Ch	esape	ake Crem	atory 8	3/3/09	Beltsv	ille, MD
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Eugeral Service Licenses		22. 1	Name and Address of I	Facility Aust	in Roy	yster Fu	neral Home
			20a. Part T. Enter the disease, or complica	M0099	6 38	21 14th	Street	NW, Was	shington	DC 20011 Approximate Interval
	Physician /Medical		failure List only one cause on each	line.					, shock, or near	Between Onset and Death
1	aminer			Hypertensive		<u>erebral he</u>	morrhage	9		
			5	e to (or as a consequence of).					
		ř	arry, reading to minited the	e to (or as a consequence of):					
		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	e to (or as a consequence of	7.					
	ted 1 Insit	Exa	events resulting in death) Last							
	execu an and al - tra	ical	X UNPENDED	AMENDED 23a,27,	per M	E g894 8/2	26/09 TT		•	
	60, tte be hysici e buri	Ned	IF FEMALE:	23c. If yes, outcome of pregi	nancy				23d. Date of deliver	у
	Box 68760 e death certificate b the attending physical for use as the bu	an/I	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 F		Ectopic pregnanc	У	Month	Day Year
	OX (sath ce attend	sici	1 Yes 2 No 9 🗸 Unknown	4 Pregnant at time of de g Unknown	atn 5 C	Other (Specify)				
	cords, P.O. Box 68760, law requires that the death certificate be execut has been signed by the attending physician and e.2 should be detached for use as the burial - tra	Physician/Medical	Part II. Other significant conditions		esulting in the	underlying cause give	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
	P,O.	ξ.						1 Yes	2 No 3 Pro	bably 4 🗸 Unknown
	ds, equire een si ould b	Completed						24a. Was an	24b. Were at	utopsy findings available completion of cause of
	COT law r has b	훁	<u> </u>					perform	ed? death?	
	tal Recieian: The certificate		25. Was case referred to medical			26.Place of	Death (Check or			
	ital sician is cert	B B	examiner?	spital: 1 Inpatient 2	ER/Outpatier	LO+	L		esidence 6 Othe	er:
	Division of Vital Records, ta or Attending Physician: The law requir as after death. The invector. After this certificate has been seled in by the funeral director, page 2 should 1	<u>٩</u>	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time of		at Work? 2	8d. Describe ho	w injury occurred	
	onding ath.	[[1 X Natural 5 Pending	(Month, Day,Year)		1Yes	s 2 No			
	risic r Atte ler des irecto n by t	[<u>2</u>	2 Accident Investigation 3 Suicide 6 Could not be	28e Place of Injury - At h	ome, farm, str	eet, factory, office buil	ding, etc. 2	8f. Location (Str or Town, Sta		ural Route Number, City
	Division pital or Attendours after death reral Director: filled in by the	Certification:	4 Homicide determined	(Specify)						
V	Division of Vital Records, P.O. Box 68760, To the Hospital or Attenting Physician: The law requires that the death certificate be execut within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and recompletely filled in by the funeral director, page 2 should be detached for use as the burial - tra		29a. Certifier	: To the best of my knowled	ge, death occ	urred at the time, date	and place, and d	ue to the cause	(s) and manner as sta	ted.
2	To the Hos within 24 h To the Fun	Medical	one) 2 Medical Examiner:	On the basis of examination a and manner stated.	ind/or investig					
16	FSFS	ž	29b. Signature and title of certifier			29c. License r			29d. Date signed (Med July 17, 2009)	onni, Day, Fear)
4		1	1 111/17. /			I UUN	E.	t t	UUIV 11, 2000	

State 31. Date filed (Month, Day, Year)
Registrar

ORIGINAL

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Ana Rubio MD.

Assistant Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 21, 2009 6:24 P Phvllis J. Noonan August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 🖫 F Director March 30,1929 Pennsylvania 195-22-3762 80 Usual Residence of Decedent 10d Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show 1 ☐ Yes 2X No Examiner is ust be notified Director Stevensville Maryland Queen Anne 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code ö "natural", or items 23a United States 21666 Funeral 104 Emory Circle 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give Specify: þ 3 ☑ Widowed 4 ☐ Divorced Year or Dates White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If Item 27 is marked other than any injury or other traumatic event, Item In Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florine H. Rutter Fred Olson 0 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stevensville, MD 104 Emory Circle; Barbara Saia - Daughter 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park Aug. 26,2009 Glen Burnie, Maryland 21. Signa re of you ral Se vice Licensee 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy. SE; Glen Burnie, MD 21061 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus __n each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Atumer: /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for self-chesquence off executed and Due to (or as a consequence of) burial-Box 68760. physician be Physician/Medical the attending p as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) P.0. the 9 Unknown 9 Unknown s been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s autopsy certificate | 1 ☐ Yes 2 ☐ No 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | → KO 2 ER/Outpatient 3 DOA 1. Inpatient After this Certification: To 28a. Date of Injury (Month, Day, Year) funeral To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director; After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

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ORIGINAL

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30. Name and address of person wap completed cause of death (Item 23a) (Type, Print)

2001

32. Registrar's Signature

Wood

in

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5, perFH, G895, 9/17/09, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Р. 5:00 A M 0echsler 24,2009 August /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harlord Bel Air Victorian Estates If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Min. 1-□ M 2 F Months Days Hours 80 Yrs. September 11, 1928 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h County 10a, State show If than "natural", or items 23a or 28a-f sho 1 ☐ Yes 2 No Directo Fallston Maryland Harlord 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21047 USA 1700 Brickhouse Lane Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Completed by Specify: White 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Housewife 12 years Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be John Which Eugenia McMakon ဂ or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter 1700 Brickhouse Road, Fallston, Maryland 21047 Janet E. Hollingsworth 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition August 26, permit. Pages Department of Important: If it any Injury or c 1 Burial 2 Cremation 3 Removal from State 2009 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 21. Signature V Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home of Dundalk, P. A. 7110 Sollers Point Road, Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ancrexia **Physician** weeks disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner emenhi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 □ No Month Dav Year 5 ☐ Other (specify) P.O. s been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ → hknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Failur 24a. Was an certificate has b rector, page 2 sh Respirating 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 14 SS Steel Liv. 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this c funeral dire Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No death, within 24 hours after death

To the Funeral Director: A 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 31195 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21206 Balamore MO 5 701 Kanwood 10/0952

State

Registrar

31. Date filed (Month, Day,

Year)

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32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2009 August 11:00AM Charles W. Orem, Sr. 22, 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death n/a 2506 Southdene Avenue Baltimore Birthplace (State or Foreign Country) if Under 1 Year | If Under 24 Hrs. 5. Social Security Number (In yrs. last birthday, Date of Birth (Month, Day, Days Hours Min. 1**X** M 2□ F 217-34-9462 2/11/1938 Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 X Yes 2 □ No n/a Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2506 Southdene Avenue 21230 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 X Married 1 ☐ Yes 2 XNo Specify: White Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Baker/Mixer Food Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Raymond Orem Doris Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gladys M. Orem / Wife 2506 Southdene Avenue, Baltimore, Maryland 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 8/25/2009 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 5 nature of Funeral Service Licen Hubbard Funeral Home, Inc. 4107 WIlkens Avenue, Baltimore, Maryland 21229

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important; If Item 27 Is marked other the any injury or other traumatic event, Item 2000.

Physician

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show

filed within 72 hours after death with the Marylanc

Baltimore, Maryland 21215-0036

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Physician/Medical Examiner attending physician and or use as the burial-tran been signed by the should be detached Completed by certificate Certification: To Be After the funeral within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The

shock, or heart failure. List only of	lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory a one cause on pach line.	rrest, Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition	. Acute CVA	hours
resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequence of): Due to (or as a consequence of):	years
Cause (Disease or injury that initiated events resulting in death) Last	c	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	23d. Date of delivery Month Day Year
Part II. Other significant conditions co		robacco use contribute to the cause of death? ¶es 2 □ No 3 □ Probably 4 □ Unknown
	24a. Was auto perfo 1	psy prior to completion of cause of death?
25. Was case referred to medical examiner?	26. Place of Death (Check only of	one)
1 Yes 2	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home SEResi	idence 6 Other (Specify)
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year) Injury Work? M 1 ☐ Yes 2 ☐ No	how injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (City or To	Street and Number or Rural Route Number, wn, State)
	ysician: To the best of my knowledge, death occurred at the time, date and place, and due to the liner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, and manner stated	

29c. License number

D5(018

29d. Date signed (Month, Day, Year)

00

State Registrar

Medical

DOuglas Pinto, MD, 31. Date filed (Month, Day, Year)

AUG 25 2009

29b. Signature and title of certi

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3421 Benson Avenue, Baltimore, MD 21228 32. Registrar's Signature

	-	For State Regis				23PII	Per Ph	n Black II per Fh Ind / Dep ny G897	tificate	3/09 Of L	J h Death				200	9	27	100
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/Medic Examir				not institution	-		mber)			Town, or	Location	of Death	·	40	c. County of	Death	40	
Funeral Director		5. Social S			6. Sex	M 2 XF	7. Age (In yrs	s. last birthday) Yrs.	If Under Months			r 24 Hrs. Min.	8. Date of E (Month, I	Birth Day, Year) 2006	1	9. Birthpl Countr		or Foreig
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No... 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month O **Physician** PERRY 5.14 PM EDITH 2 2 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Levindale If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex Age (In yrs. last birthday) Funeral Year) Min. Months Days Hours 1 M 2 P 7-24-988 lan Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Des 2 No Director laryland 10g, Citizen of What Country? 10e. Street and Number 5120 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item any Injury or other traumatic event, the Medical Examiner 1 ☐ Yes 2 ♣ If Yes, Give Year or Dates: 2 110 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Baltimore County Schools Elementary/Secondary (0-12) College (1-4or 5+) Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be son Smi Mar eemes ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ohen/ 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 Removal from State Cathedral 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) ADVANCED DEMENTIA **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending pl for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 ☐ Probably 4 ☐ Unknown 2 No 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1☐ Yes To the Hospital or Attending Physician; funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 20 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 1 Yes 1 🔲 Inpatient Certification: To 2 ER/Outpatient After this 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural after death. 1 TYes 2 Accident filled in by the 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar

e Funeral

within 2

31. Date filed (Month, Day, Year) AUG 25

29b. Signature and title of certifier

29a. Certifier

Medical

32. Pegistver's Signatur barka

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEVINDALE DR ALANA ARNAMI 2434 W. BELVEDERE AUENLE

MD

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

68394

29d. Date signed (Month, Day, Year)

BALTIMORE

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month (Judith 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death NA Baltimore Joseph Ritchey Hospice If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday)
70 Yrs. Date of Birth (Month, Day, 08-09 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Months Days Hours 1 □ M 2 🗓 F 219-26-4553 MDUsual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State X yes 2 □ No Baltimore NA MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21216 Walbrook Avenue Apt#303 2725 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. African 11. Marital Status 1 □Yes XIVNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 X No Specify 3 Widowed 4 Divorced American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Health Care Provider Nursing Home 12th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jones Lillian Booze Clarence 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sister 11524 Charlton Drive Silver Spring, Winifred B. Wallace 20a. Method of Disposition
1 □ Burial 2 □ Oremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 4 ☐ Donation 5 ☐ Other (Specify) 08-21-09 Catonsville, MD Crematory Wylie Funeral Home P.A. 21. Signature of Fuperal Service Licensee 22. Name and Address of Facility 638 N. Gilmor Street Baltimore, MD 21217 23a. art1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Let only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. R No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 ☐ Yes 2 X No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Examiner attending physician for use as the burial requires that the death certificate be as the the cate has been signed by page 2 should be detach Hospital or Attending Physician: The

Physician

/Medical

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Examiner Physician/Medical ģ Be Completed Certification: To completely filled in by the funeral

Physician

/Medical

Examiner

Director

Funeral

<u>ک</u>

Be Completed

2

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" or itemate.

1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Location (Street and Number or Rural Route Number, City or Town, State)

29a Certifier To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The decay is a state of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Medical

AUG

31. Date filed (Month, Day, Year)

within 24 hours after death To the Funeral Director:

Box 68760 P.0. of Vital Records, Division or Attending

Baltimore, Maryland 21215-0036

filled in by the f within 24 hours a

1 □Yes 2 □No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Parkville

D0069314

8813 State

31. Date filed (Month, Day, Year) AUG 25 2000

Waltham

32. Registrar's Signature

Ld

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Moods

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.-2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death AUGUST 2009 RUNYON 2:30 P M MILDRED 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death FOREST HILL HARFORD FOREST HILL HEALTH & REHAB CENTER 8. Date of Birth (Month, Day, Year) 10-28-1924 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2 🗓 F Months Days Hours 84 219-12-6223 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 X No Baltimore Kingsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 812 Petem Rd 21087 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lohmie Hughes George Washington Evans 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 812 Petem Rd Kingsville, MD 21087 Gerald Schultz (son in law) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 08-25-2009 Timonium, MD Dulaney Valley 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licenses Inc 610 W. MacPhail Rd BEL Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final end stage dement disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Jause (uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an

Physician /Medical Examiner

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attending p

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physician

Hospital or Attending Physician: The law requires that the death certificate be execute

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any Injury or other trau once.

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

28a-f show

Director

Funeral

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Completed

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th and Mental Hygiene. 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Exartirer must be rediffed at

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

altimore, Maryland 21215-0036

Examine Physician/Medical P Completed Be

After this certificate has been signed by the funeral director, page 2 should be detached Certification: To filled in by

IF FEMALE 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown

1 Yes 2 No

27. Manner of Death

1 Natural

2 ☐ Accident

3 Suicide

29a. Certifier

4 Homicide

25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

21014

autopsy performed 1 ☐Yes 2 No

Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier

David 5

29c. License number

322

BEL AIR, MD.

29d. Date signed (Month, Day, Year) Que, UST 21, 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

615 W MACPHAIL ROAD DAVID DUNN 31. Date filed (Month, Day, Year)

AUG 25 2009

5 ☐ Pending investigation

6 □Could not be

32. Registrar's Signature

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completely within 2.

> State Registrar

Medical

DHMH 17 Rev 1/2001

n 24 hours after death.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 20th 2009 15:56 P M **Physician** August Sidney David Renick /Medical 4b_City, Town, or Location of Death 4c. County of Death 4a. Eacility Name (If not institution, give street and number) **Examiner** Baltimore HOS AIT aL N/A st - fignes If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 6. Sex 1 → M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 068-05-3976 93 March 301916 New York Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2 X No Catonsville Director Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21228 719 Maiden Choice Lane, BR213 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Tayes 2 No If Yes, Give WWII Year or Dates: 1 Never Married 2 X Married 1 ☐Yes 2 No Specify Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clothing Industry 12 Buver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bessie Katz Max Renick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 407 Butternut Court, LaPlata, Maryland 20646 Barbara Graves 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date August 2009 22 1 ☐ Burial 2 Tremation 3 ☐ Removal from State Metro Crematory,Inc 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland Cremation Society of Maryland, 299 Frederick Road Baltimore, Maryland 21. Signature of Funeral Service Licenses Alice Iser 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1) seare eas MOMONO **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner evere Au tic Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) ears. Midh 11) 200 Se Physician/Medical IF FEMALE: 23c. if yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 2 No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 □ Yes 200No 1 Dopatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐Yes 2 ☐No

Division of Vital Records, P.O. Box 68760, aftending physician certificate this Hospital or Attending Pl 24 hours after death. Funeral Director: After the

the as for use a director,

burial-trar funeral c filled in by the

?7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exemples must be notified at

th and Mental Hygien 7 is marked other the

permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any In]ury or other trau

72 hours after

Saltimore, Maryland 21215-0036

within 24 hours a

To the Funeral D Medical

State Registrar

6 ☐ Could not be

29b. Signature and title

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Descriping Physician: To the best of my knowledge, decar occurred at the limb, date and place, and due to the cause(s) 2 ■ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

NPI: 17 30335678

son who completed cause of death (Item 23a) (Type, Print) ND-900 Caton Avenue, Baltimore-HD 21229

Movales

31. Date filed (Month, Day, Year) AUG 25

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryland		artment o				giene)9	27120
	* *		1. Decedent's Name (First, Middle, Last						2. Date of Dea Month	ith Day	Year	3. Time of Death
7	Physici /Medic		Jessie H	oman Smile	У				August	20,2		8:10рм
	Examin		4a. Facility Name (If not institution, give				n, or Location	of Death			y of Death	,
			Manor Care Nurs				eaton				tgom	
1	Funeral Director		5. Social Security Number 6. Se 577–12–1329	7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 You Months Da	ear If Under lys Hours	Min.	8. Date of Birth (Month, Day 03/30/	7 Year) 1920	9. Birthp Cour D	place (State or Foreign http) • C •
	р ,		Usual Residence of Decedent	100 City	, Town or Lo	eation						10d. Inside City Limits
	ahov	'n	MD Charle			fret						1 ☐ Yes 2 ☑ No
	28a-f	Director	10e. Street and Number			10f. Zip Cod	de .			10g. Citizen of	What Cou	ntry?
	3a or			1 Road		206				U	SA	
	ms 2;	Funerai	11. Marital Status	12. Was Decedent Ever in U.S	S. 13.	Was Decedent	of Hispanic Or	igin? (Spe	ecify Yes or No- Rican, etc.)	14. Ra	ce - Americ	
36	a within 72 hours after death with the Maryland jiene. r than "natural", or itema 23a or 28e-f ahow the Madical Examiner must be notified at	by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 M No If Yes, Give Year or Dates:		irres, specily (1 ☐ Yes 2 🛣			nican, etc.)	Į.	ack, White, <i>ify:</i> Wh	
8	hour tural		15. Decedent's Edu		16a Dece	dent's Usual Oc	ccupation			16b. Kind of I	Business/In	idustry
5	in 72 an" r	ojet	(Specify only highest grad	le completed)	(Give	kind of work do DO NOT use re	one during mos	st of worki	ing			ŕ
212		Completed	Elementary/Secondary (0-12) 1 2	College (1-4or 5+)		Homema	aker			Own	Home	
٦	othe	Be C	17. Father's Name (First, Middle, Last)		-				(First, Middle,			
Maryland 21215-0036		To	Lester Sta	inley Homan	10h Mait	na Address (St			Leona			n Code)
	nd 2 s lith ar 27 ts r trau		Bonnie S. Payne	Daughter	8890	Lowe	Ll Roa	.d, F	Pomfret	E, MD	2067	5
J.e.	of Hea of Hea fitem r oths		20a. Method of Disposition 1 ☐ Burial 2X☐ Cremation 3 ☐	Ce Ce	emetery, cre	osition (Name of matory or other	place)		Date	20c. Location		
<u>H</u>	Pages ment of ant: If it ury or o	13	4 □Donation 5 □ Other (Specify)	ALC		Cremat			/2009	Hano	ver,	MD
Baltimore,	permit. Pages Depertment of I Important: If it any injury or or once.		21. Signature of Funeral Service Lizens	⊕Dorota Mars Uu XVII	shall ²	2. Name and A Maryl	and C	rema	tion S	ervic	es D 21	202
	4- 1-		23a. Part . Enter the disease, or comp shock, or hearn failure. List only of	lications that caused the death	. Do not en	ter the mode of	dying, such as	s cardiac o	or respiratory ar	rest,	U-2 I.	Approximate Interval Between
	Physician		Illillediate Cause (Final									Onset and Death
FAL	/Medical		disease or condition resulting in death)	a. Alzheimer Due to (or as a consequ		ısease						
	Examiner		Sequentially list conditions,	b								
	D ==	iner	cause. Enter Underlying Cause (Disease or injury	Due to or as a cons	ience of:							
	ecute and trans	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequ	ianoa of):						_	
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68760,	phys phys s the			d								
×	leath certificate b attending physicate to the terms of the terms.	/We	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna						23d. D	ate of deliv	very
Вох	death a atter d for u	Physician/Medi	in the past 12 months? 1 □ Yes 2 ☑ ¥0	1☐Live birth 2☐Fetat 4☐Pregnant at time of de		⊒Ectopic pregn ⊇Other (s <i>pecif</i>				N	J onth	Day Year
P.O.	by the detached	hysi	9 Unknown	9□ Unknown								
	as the gned	þ	Part II. Other significant conditions co	ontributing to death but not resu	ulting in the t	underlying caus	e given in Part	l.		obacco use co Yes 2□No		the cause of death?
oro	w require been si	eted							-	-		
Records,	has b	Completed								osy ormed?	prior to death?	opsy findings available ompletion of cause of
a			05.116					45		2 🔀 No	1 🗆 Yes	2 □ No
of Vital	Physician: r this certificant all director,	Be C	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	int 3□ DOA	Othor		h <i>Check only o</i> ome 5 ☐ Resid		ther (Spec	(6)
		. To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time		Injury at Work?		28d. Describe			пуу
on	th. After s funera	ij	tXXatural 5 ☐ Pending 2 ☐ Accident investigation		Injury	м	Work? 1 ☐ Yes 2 ☐]No				
Division	or Attendia after death. Director: A in by the fu	Certification:	3 Suicide 6 Could not be determined	288. Place of Injury - At he	ome, farm, s	treet, factory, of	fice		28f. Location (. City or Tox	Street and Nur	nber or Rui	ral Route Number,
á	s after al Direct	Cert	4 Homicide	building, etc. (Specify	r)				Ony or 701	wii, Otato)		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Medical (ysician: To the best of my kno niner: On the basis of examina and manner stated.								
	o the	Me	29b. Signature and title of certifier	η η /		29c. L	icense number			29d. Date sign	ned (Month	, Day, Year)
	F \$ F 0		> 1.11 L	1 Soul	1,	D	52261			8	/21/	2009
			30. Name and address of person who	completed cause of death (Item	23a) (Type	, Print)						
			Alan R. Segal,	//	/		Silve	er S	pring,	MD 2	0906	
E.	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture							
18	Regist	rar	AUG 2 5 2009	Marcha B.	barr	Les .						

DHMH 17 Rev 1/2001

16

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 08-19-2009 **Physician** 1135 P Valeria C. Spangler /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Timonium Baltimore Stella Maris Birthplace (State or Foreign Country) MD 8. Date of Birth 08-23-1925 5. Social Security Number If Under 1 Year | If Under 24 Hrs 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🗓 F 83 **Director** 212-20-4664 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County If Item 27 Is marked other than "natural"; or items 23a or 28a-f shov or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√ No Director Forest Hill Harford MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21050 USA 308 B Willrich Cir. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: ð 3 Widowed 4 Divorced White Completed 15. Decedent's Education fy only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Blue Cross Blue Shield Computer Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Valeria Freburger Thomas E. Mitchem 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health a Important: If Item 27 Is any injury or other trau 1405 Bankert Terrace Abingdon, MD 21009 Bernard E. Spangler, Jr. (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 08-21-2009 Baltimore, MD 4 □ Donation 5 □ Other (Specify) Bayview Crematory 22. Name and Address of FacilitySchimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee Inc. 610 W. MacPhail Rd Bel Air, MD 21014 Approximate Interval Between Onset and Death 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CEREBROVASCULAR ACCIDENT Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): physician and the purial-t Physician/Medical attending p for use as 1 IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) the 1∐Yes 2**X**No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

2009

AUGUST 19,

VALERIA SPANGLER

Division

of Vital Records, P.O. Box 68760 signed by t

certificate has page Physician: After this

Completed

Be

Certification: To

Medical

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy perform 1 ☐ Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 ☐ Yes

	25. Was case referred to medical	26. Place of De	ath (Check only one)
ļ	examiner? 1 ☐ Yes 2 😿 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing	Home 5 ☐ Residence 6 X Other (Specify) HOSPICE
ľ	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation		28d. Describe how injury occurred
	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier theck only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Nurse Practitioner estated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed ause of death (Item 23a) (Type, Print)

JENNIFER HÄUF, CRNP/ 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

31. Date State Registrar

ours after death.

neral Director: A
filled in by the fu

To the Hospital within 24 hours a To the Funeral C Hospital

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. AMEND ITEM#29d perPHYS G894, 8/25/09 WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Elizabeth Schuldt 2100 M Dorothy must 2009 18 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Seasons Hospice Randallstown Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6/22/1919 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F Months Days Hours Min. 90 Vrs 225-16-0118 **Director** Virginia Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f short a Medical Examiner must be notified at Director 1 ☐ Yes 2 🔀 No MD Baltimore Randallstown 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Apt #102 21133 U.S.A. 8602 Gray Fox Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No þ Specify. Specify: 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygienn Important: If item 27 Is marked other than any Injury or other traumatic event, it a ginds. 11 Homemaker 17. Father's Name (First, Middle, Last). UNK 18. Mother's Name (First, Middle, Maiden Surname) Be UNK 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Deluca/ Daughter 7409 Village Road Apt# 3, Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry 4 Nonation 5 ☐ Other (Specify) 8/19/2009 Hanover, Maryland 21. Signature of Juneral Serie Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste.P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS /Medical Due to (or as a consequence of): Examiner schemic bowe Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE: yes, outcome of pregnancy

☐ Live birth 2 ☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 TNo 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other Spenisons Hospital Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 □Yes 2 □ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

the death certificate be executed sician and burial-trans Box 68760, attending physician for use as the buria signed by the a P.O. of Vital Records, page 2 s certificate Physician: director. this Division Hospital or Attending death. 24 hours after deat Funeral Director: filled in by completely within 2

28a-f show

Maryland 21215-0036

Baltimore,

within 72 |

29d. Date signed (Month, Day, Year)
August 18, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) old Court Road Baltimore MD 21133 5400 ton 31. Date filed (Month, Day, Year, 32. Registrar's Signature AUG 2 5

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Medical

State

Registrar

(Check only one)

29b. Signature and title of certifie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) August 23 Physician/ 2009^{Year} Still Robert James 5:27 A M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Center for Hospice Towson 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 07/31/1936 Maryland Director 219 30 4726 73 Usual Residence of Decedent show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State Director 1 🗆 Yes 2 🔀 No Maryland Baltimore Essex 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA Funeral 21221 2410 Baurnschmidt Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian Black, White, etc. Completed by 1 Never Married 2 X Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Yes, Give Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Drywall Company Owner/Operator Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) ၉ Edna Louise Szech Jacob Edward Still 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 23,2009 2410 Bauernschmidt Drive Essex Maryland 21221 Charlotte A. Still (wife) 20a. Method of Disposition
14 Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Aug 26,2009 Baltimore Maryland Oak Lawn Cemetery ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home PA Sila se of Funeral Service Lic 1407 Old Eastern Avenue Essex Maryland 21221 r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one called or each line. Approximate Interval Between Onset and Death . Part Enter the disease August shoo or heart failure. Li Imm diat : Cause (Final Physician/ disea 100 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for as a consequence of: Examine cause. Enter Underlying Cause (Disease or iinjury g physician and as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical attending IF FEMALE for use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Dav Pregnant at time of death this certificate has been signed by the and director, page 2 should be detached 9 Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy death? 2 🗌 No Yes 2 1 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home မ within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: (Month, Day, Year) Natural 5 Pending work? M Investigation Could not be Accident 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29a. Certifier

(Check

only one

3 E

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32

aistrar's Signature

29b. Signature and title of certific

31. Date filed (Month, Day, Year)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

N Zit

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	State	of Maryland / Dep	artment of Hea		ental Hygiene Reg. No.	2 11 11 0	27121
			1. Decedent's Name (First, Middle, Last)		7111100110 01 00		2. Date of Death		3. Time of Death
	Physicia	an	Nancy June	Smith			Month Day August 20,		12:30 P ^M
1	/Medic		4a. Facility Name (If not institution, give street and	number)	4b. City, Town, or Loc			County of Death	
	Examin	er	4018 Briar Point Road		Middle Ri			Baltim	ore
**	Formation		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday	If Under 1 Year If	Under 24 Hrs. 8	B. Date of Birth	9. Birth	place (State or Foreign
	Funeral Director		235 52 7806 1□M 2X	74 Yrs.	Months Days F	Hours Min.	(Month, Day, Year) April 13,1		virginia
-			Usual Residence of Decedent	1-1-1-					
	ylan how		10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits
	a-fs	cto	Maryland Baltimore	Middle	River				1 □Yes 2□No
	or 28	Director	10e. Street and Number		10f. Žip Code		10g. Cit	izen of What Cou	intry?
	th wi	la [4018 Briar Point Road		2122			USA	
	ems	Funeral	Armed		Was Decedent of Hispa If Yes, specify Cuban, M	anic Origin? (Spec Mexican, Puerto R	ify Yes or No- ican, etc.)	 Race - Amer Black, White 	
36	i within 72 hours after death with the Maryland jiene. r than "naturel", or items 23a or 28a-f show the Modeal Expolirer must be rediffed at		If Yes.	es 2 XNo Give	1 □Yes 2 No S	Specify:		Specify: Whi	
21215-0036	urel"	Completed by	A	or Dates:	edent's Usual Occupatio	20	16b K	ind of Business/li	
15-	"nat	lete	15. Decedent's Education (Specify only highest grade complete	ed) (Give	e kind of work done duri DO NOT use retired)	ng most of working	7		,
12	within iene. than "	Ę	Elementary/Secondary (0-12) Colleg	e (1-4or 5+)	vision Manad		- 1	tate of	Maryland
d 2	플 수 를 투		17. Father's Name (First, Middle, Last)				(First, Middle, Maiden		<u> </u>
Maryland	Q = Q 9	To Be		ller		Gertru	de Steph	enson	
Z.	s 1 and 2 should I f Health and Men fem 27 Is marke other traumatic	-	19a. Informant's Name/Relationship (Type. Print)		ing Address (Street and				
S	od 2.		Brenda Laubach (daught	ter) 4018	Briar Point	t Road Mi	iddle Rive	r, Maryl	and 21220
ē,	es 1 and 2 of Health a f Item 27 is		20a. Method of Disposition	20b. Place of Disp	osition (Name of ematory or other place)	Da	te 20c. L	ocation - City or 1	own, State
9	Pages nent of int; If Its iry or o		ND Burial 2 ☐ Cremation 3 ☐ Removal fr 4 ☐ Donation 5 ☐ Other (Specify)	om State Holly Hi	ll Mem Gard	en\$ 8/24,	/2009 Balt	imore Co	ounty, Md.
Baltimore,	permit. Pages Department of Important: If II any Injury or o		21. Sin ture of Funs al Service License		22. Name and Address of	4 = 100	ruzdzinski		
ä	Der	0 0	# 1202		1407 Old Eas				
			23a. art1. Enter the disease, or complications the cock, or heart failure. List only one cause						Approximate Interval Between
	Physician		Immediate Chuse (Final						Onset and Death 2 YRS.
	/Medical		regulting in death)	D STAGE RENA to (or as a consequence of):	L DISLASE				Z IND.
т	Examiner		TN	SULIN DEPEND	ENT DIABE	TES MEI	LLITUS		25 YRS.
		je l		to (or as a consequence of):	111111111111111111111111111111111111111				
	outed Id ansit	Examin	Cause (Disease or injury that initiated events						
oʻ	an ar rial-t		resulting in death) Last Due	e to (or as a consequence of):					
8760	The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit	dical	d						
9	ng ph as th	Jed	IS SCHALS:				-		
Box	eath certific attending p	Physician/Me	23b. was decedent pregnant	, outcome of pregnancy .ive birth 2 ☐ Fetal death 3	☐ Ectopic pregnancy		ľ	23d. Date of del Month	ivery Day Year
	dea he at ed fo	sici	1 Liyes 2,XLiNo 9 ∏ L	regnant at time of death 5 Jnknown	Other (specify)			WIOTH	July 104
P.O.	at the de by the stached	٦	9 ∐ Unknown			in Don't	23a Did tobacco	use contribute to	the cause of death?
	res tha		Part II. Other significant conditions contributing		underlying cause given	in Part I.			obably 4 Unknown
ord	w requir s been s should	ted	Rheumatic Heart D	<u>isease</u>			1 163 2		
ec.	law r as be 2 sh	eg.	<u>Mitral Valve Dise</u>	ase			24a. Was an autopsy	prior to	topsy findings available completion of cause of
of Vital Records,		Completed by	Congestive Heart	Failure			performed? 1 □Yes 2 ☑ N	death? o 1 ☐ Yes	2 ⊠No
'ita	Physician: The this certificate ral director, pag	Be (25. Was case referred to medical			26. Place of Death			
<u>_</u>	Physic this co al dire		1 ☐ Yes 2 🔀 No	1 ☐ Inpatient 2 ☐ ER/Outpati		4 🗆 (Vulsing 110)	ne 5 Residence		cify)
u u		ii o	27. Manner of Death 1 ★Natural 5 Pending	Date of Injury 28b. Time Month, Day, Year) Injury	Work?		8d. Describe how inju	iry occurred	
sio	Attending ir death. ector: After by the fune	cati	2 ☐ Accident investigation			s 2 No	Of Leasting (Chart	and Aliumbar or Di	um I Pauta Number
Division		Certification: To	4 Homicide determined 28e. F	Place of Injury - At home, farm, soulding, etc. (Specify)	street, factory, office	2	28f. Location (Street a City or Town, Sta		arai nobie ivallibei,
	pital or ours afte eral Dir filled in		29a. Certifier 1 🔀 Certifying Physician: T	o the best of my knowledge, de	ath accurred at the time	date and place	and due to the cause	(s) and manner a	s stated.
1	Hos 4 h Fun Fun tely	Medical	(Check only 2 Medical Examiner: On	the basis of examination and/or manner stated.	investigation, in my opir	nion, death occurre	ed at the time, date a	nd place, and due	to the cause(s)
)	To the Hos within 24 hor To the Fun completely	Mec	29b. Signature and title of certified		29c. License n	number	29d. D	ate signed (Mont	h, Day, Year)
	ĕ≱≓ŏ		Mula	M. D.	D001	17728	Aug	ust 20,	2009
			30. Name and address of person who completed			1120	Aug	200 201	
			Ba Yin Oung, M. I	0000 -		Ва	ltimore,	MD 21	L236
	St	ate					•		
	Regist		AUG 2.5 2009	32. Degistrar's Signature	arker				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 19a, per FH g894 8/25/09 TT

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Day **Physician** :10 10RiA 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ARSWell BATTIMOVE If Under 1 Year | If Under 24 Hrs. Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 256-38-272 1 ☐ M 2 🔀 F Months Days Hours Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 shov any Injury or other traumatic event, It. My dical Evaria in the institute of **Funeral Director** 1 Yes 2 No Timor m.D 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 | Yes 2 | No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Be Completed by BIACK 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home 10 glade NONE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ic/or 19a. Informant's Name/Relation ship (Time Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Limmie mn 2/2/8 20c. Logation - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Pages 1 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mem. AK QugusT 28,200 21. Signature of Funeral Service Licensee 22. Name and Address of Facility

Betts Fun esch CAROlin-ST laccion Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** concreative mon disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Disc to for as a consequence off or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 5 Other (specify) 9 Unknown ייייי אוויסן serumcate has been signed by funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 🗌 Yes 2 🗆 No 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide the Hospital 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Di5546 24 Aug 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles Padgett, MD 5601 Loch Raven B

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

5

Darka

32. Registrar's Signature

5601 Loch Reven Blue, Ballimore, MD 21239

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) August 18 ay 2009 ear 8:45 AM **Physician** Stang Nellie L. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Baltimore 2808 Hoffman Avenue 8. Date of Birth 2-10-1924 Birthplace (State or Foreign Country)

MD If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1□ M 2 F Months Days Hours 85 216-16-3852 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'm Widical Examiner must be notified at 1 ☐ Yes 2 XNo Director Baltimore Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number **USA** 21227 2808 Hoffman Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married White 1 □ Yes 2 X No Specify. Specify Be Completed by 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Own home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be f ment of Health and Mental I ant: If item 27 is marked of Edna Mae (unknown) George Taylor ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Arbutus Avenue Halethorpe MD 21227 Department of Health Important: If Item 27 any injury or other tr. once. Diane Nicolai 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Durial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie MD 8-21-2009 Cleh Haven Cemetery 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne une 2719 Hammonds Ferry Road Lansdowne MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause or place line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Enysicia**n /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 PYes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 2 11 No 1 Inpatient 2 ER/Outpatient 3 DOA 1∐ Yes Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 □Yes 2 □ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division of Vital Records, or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific To the Hospital

requires that the death certificate be executed

Box 68760,

P.0.

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

and manner stated.

Catensville MD 21228

1 fortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Day, Year) 31. Date filed (Month,

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2009 1:00 p Barbara Α. Sanders August 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore City Baltimore Joseph Richey Hospice If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex Days 1 □ M 2 🔀 F 218-36-9167 69 11 1939 West Virginia Dec. Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b. County ty∑Yes 2 No Maryland Baltimore City Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3939 Roland Avenue, Apt.110 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Jolliffe Audra Marydell Wagner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3939 Roland Ave., Hope A. Sanders/ Daughter Apt110, Baltimore, Maryland 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State August 24. 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Metro Crematory, Inc. | 2009 | Baltimore, Maryland easton | 22. Name and Address of Facility Cremation Society of Maryland, Inc. 2009 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) Aman a Heaston Signature of Funeral Service Licensee 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Months disease or condition resulting in death)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a, State

Director

Funeral

2

Completed

Be

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Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinational be notified at

Health a

permit. Pages 1 and 2 Department of Health Important: If item 27 any Injury or other tra once.

Physician/Medical Examiner burial-trar physician attending p signed by the a Be Completed by page 2 should certificate Medical Certification: To After nours after death.
neral Director: /

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

	Due to (or as a consequence of).	1)
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence of):	
that initiated events resulting in death) Last	C	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	23d. Date of delivery Month Day Year
Part II. Other significant condition	ns contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
		24a. Was an autopsy performed? 1 \(\text{Yes} \) 2 \(\text{No} \) 1 \(\text{Yes} \) 2 \(\text{No} \) No
25. Was case referred to medical	26. Place of Death	(Check only one)
examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hon	ne 5 Residence 6 Sother (Specify) Husmu
27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	(Month, Day, Year) Injury Work?	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		Ref. Location (Street and Number or Rural Route Number, City or Town, State)
	Physician: To the best of my knowledge, death occurred at the time, date and place, a xaminer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	

29c. License number

29d. Date signed (Month, Day, Year)

V

State Registrar

within 24 hours a

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hennawi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 29d per me, g894 08/25/09dhb Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** DIKORSKI 2025 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** KYNIE PA If Under 8. Date of Birth (Month, Day 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** July 4, Months Days Hours Min 1 M 2 □ F Maryland 54 Director 220-66-5542 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 28a-f show ir than "natural", or Items 23a or 28a-f sho 1 ☐Yes 2 No Director Maryland Anne Arundel Pasadena 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7749 Edgewood Avenue United States Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Ite ury or other traumatte event, if a featural to a featura 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐Yes 21 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter 10 Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Doris ္ရ John Muhl Sikorski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brittany Sikorski-Bowles/ Daughter 9803 Old Scotland Road, Shippensburg, PA 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date permit. Pages 1
Department of F
Important: If Ite
any Injury or ot
once. August 18, 2009 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory, Inc. 2009 Baltimore, Falyland, Inc. 22. Name and Address of Facility Cremation Society of Maryland, Inc. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Amanda Heaston manda 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed ours after death. It is certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 □ No 1 ☐ Inpatient 2 ☐ R/Outpatient 3 ☐ DOA 1 Yes Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day August 18, 2009 29c. License number eouty ause of death (Item 23a) (Type, Print) 30. Name and address of person who cor 3 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

AUG 25

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Day **Physician** August 21, 2009 David Milton Silling 9:47 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford 1414 Old Joppa Road Joppa 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1**½** M 2 □ F Director Maryland <u>214**-**80-2540</u> 17. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 23a or 28a-f show event, the Midical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Harford Joppa 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number 1414 Old Joppa Road 21085 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) items ; 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ∐Yes 2 If Yes, Give 2X No 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐Yes 2 No Specify: þ 3 Widowed 4 Divorced Year or Dates White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) County Government Park Attendant 7 Is marked other traumatic event, 1" 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Grayson Oliver Silling ၉ Carolyn Morgan Duncan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 Is any injury or other tra 1414 Old Joppa Rd., Joppa, MD 21085 Kathleen A. Silling / Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State p Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Memorial Gdn. 8-26-09 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensie 22. Name and Address of Facility McComas Funeral Home, P.A. Whiten CF Sathleen 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** OCOM4/Y disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Justo (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transi Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) this certificate has been signed by the a director, page 2 should be detached if 2 ☐ No 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐ No 2 🗷 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Viteen

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

AUG

32. Røgistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Day Physician August 18, William E. Smith, Sr. 2009 12:04 P. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Keswick Multicare Center Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year Months Hours Days Dec. 4, 213-34-0944 72 1936 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at XX Yes 2 □ No Maryland N/A Baltimore Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code r than "natural", or Items 23a or the Medical Examiner must be r 804 Berry Street 21211 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes **XX**No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Specify: White 1 ☐ Yes 2 🛛 No Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Elementary/Secondary (0-12) College (1-4or 5+) Forestry and Parks Group Leader Baltimore City Department of Health and Mental Hygic Important: if item 27 Is marked other i any Injury or other traumatic event, <u>the once.</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Basil Smith Catherine Rotosky ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Shirley Ann Smith Wife 804 Berry Street, Baltimore, Maryland 21211 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🔀 Burial 2-□Cremation 3 □Removal from State Crest Lawn Memorial | 8/24/2009 Marriottsville, Maryland Dother (Specify) 4 Donatio 21. Signature of Pineral Service Licens 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc 3631 Falls Road, Baltimore, Maryland Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CLYV hos 15 Due to (or as a confequence of): Physician /Medical Examiner Sequentially list conditions, if an, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine physician and s the burial-trans Due to (or as a consequence of) Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No CONTESTIVE 24a. Was an autopsy 2 INO Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death | Director: A d in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, < within 24 hours aft

To the Funeral Di

completely filled in

death with the Maryland

Baltimore, Maryland 21215-0036

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

(more pully)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5901 North CHAPLES Street Baltimore HILARY DON M.P. 31. Date filed (Month, Day, Year)

State Registrar

AUG 25

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Year 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** ALG Mildred V. Sanford 0:00 600 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hall 9 N/A IMU 2 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/26/1913 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Months Days Hours Baltimore, 1 □ M 2 🕱 F MD. 96 Director 219-30-5066 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland nd Mental Hygiene.
marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the Medical Experiment must be putified at 1 ☐ Yes 2 🔀 No Director MD Baltimore Catonsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 709 Maiden Choice Lane RGT110 21228 Funeral 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Education/College 12 <u>Secretary</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any lipiry or other traumatic event once. Frederick Reinhold Emma Schnephe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2 Rolling Greens Court, Lutherville, MD 21093 Mr. Robert G. Sanford (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Cemetery 08/26/2009 Timonium, Maryland Donation 5 Other (Specify) ure of Funeral Service Loensee 21 Sign 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 Approximate Interval Between Onset and Death 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each light Immediate Cause (Final disease or condition resulting in death) day **Physician** /Medical ce of): Due to (or as a consequ Examiner WEV. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 □ Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No 2 ER/Outpatient 3 DOA ___mpatient Certification: To 28b. Time of 28a. Date of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) Injury 1 Natural
2 Accident 5 ☐ Pending 1 ☐ Yes 2 ☐ No death. investigation after death Director: / completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide e Funeral 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) raminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address lavo Wareh 16502 NOID

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32, Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1009 AMORDUST 4: 15 P.M George William Scaljon 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death erelh POIN MARYLAND HEALTH PARE SYSTEM PERRY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, 10/31/1920 Birthplace (State or Foreign Country) Months Days Hours Turkey 219 01 7132 88 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1X Yes 2 No MD Cecil Perryville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21903 709 Concord Point Dr. U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status ed Forces? Yes 2 ☐ No 1 [**2**¶Ves 2 ☐ No If Yes, Give Year or Dates: **₩W**II 1 Never Married 2 Married 1 ☐Yes 2 🛣No Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life_DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Metal Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Esther Vicos William Scaljon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 709 Concord Point Dr. Perryville, MD Angela Scaljon (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Greek Orthodox of St. Demetrios 1 → Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Parkville, MD 21. Signature Funeral Service 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a. art Enter the disease shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Approximate Interval Betweer DREWARD Peath PANDER Immediate Cause (Final OF HEAD disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 📮 No 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran attending physician for use as the buria signed by the a

Physician

/Medical

Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Funeral Director

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Exycontant roust be redthed at once.

ME KNOWN TO PHYSIPIN ... Baltimore, Maryland 21215-0036

Exami Physician/Medical þ certificate has been si rector, page 2 should ! Be Completed Certification: To

n 24 hours after death.

e Funeral Director: Af within 24 hor To the Fune completely fi

Division of Vital Records, P.O. Box 68760,

Registrar

Medical

31. Date filed (Month, Day, Year)
AUG 25 State

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29a, Certifier

and mannel stated.

DHO723

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VA MARYLAND MONAH 15AAC

HEALTH CARE SYSTEM, DERRY POINT, MD 21902

2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar			nate o	i iviai	ylaria /		tificate of				leg. No.			
		_	1. Decedent's Nam	e (First, Middi	e, Last)								Date of Dea Month	th Day	Year	3. Time of I	Death
	Physicia /Medic		Addolo	rata D	olore	s Tro	oiano	0					August	19,20	009	1:30P	M
-	Examin		4a. Facility Name (4b. City, Town,	or Location	of Death		4c. Co	ounty of Dea		
				arleig		Apt	.1C			Not If Under 1 Year	tingh	am r 24 Hrs.	8 Date of Birth	h	Balt	O • thplace (State or	r Foreian
	Funeral	- 1	5. Social Security N		6. Sex 1 ☐ M	2 X F		(In yrs. last	birthday) Yrs.	Months Days			8. Date of Birtl (Month, Day		C	ountry)	roreign
	Director	-	218-36-24 Usual Residence o	07 f Decedent			_73						April 3	0,193	00 IE	aly	
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	or 28	Director	10e. Street and Nu							10f. Zip Code				10g. Citize	n of What C	ountry?	
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	er de	Funeral	 Marital Status Never Mari 	ded OV Ma		Was Dece Armed Fo 1 ☐ Yes	rces?		13.	Was Decedent of If Yes, specify Cul	ban, Mexic	an, Puerto	Rican, etc.)	I	Black, Whi	te, etc.	
36	rs aft	2	3 🗋 Widowed			If Yes, Gi Year or D	ve T			1∐Yes 2∭XNo	Specif	y:		S	pecify: W	hite	
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21	ed wir	ပ္ပ		th	1 1)				Super	rvisor	18 Mot	har's Nam	e (First, Middle,	Tail Maiden Si			
and	be fill d out		17. Father's Name		Last)								DiVinc				
Maryland	hould d Me mark matic	ည	John Se		shin (Tyne	Print)			19b. Maili	ng Address (Stree					Town, State,	Zip Code)	
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re,	Pages 1 and 2 should be filed within rent of Health and Mental Hygiene. nt: If item 27 Is marked other than rry or other traumatic event, the Merica or the traumatic event even		20a. Method of Dis	sposition				20b. Plac	e of Dispo	osition (Name of matory or other pl	ace)		Date	20c. Loca	ation - City o	r Town, State	
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modeal Evantinal must be notified at once.	1	21. Signature of F	uneral Service	Licensee	<			2	2. Name and Add							
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Division	or A after Direction by	Certification: To	4 🗌 Homicide	dete	mined	buile	ding, etc.	. (Specify)	, ,				City or To	wn, <i>State)</i>			
_	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use		29a. Certifier	1 Certify	ing Physi	cían: To th	e best o	of my knowl	edge, dea	ath occurred at the investigation, in m	e time, date	and place	e, and due to the	e cause(s)	and manner	as stated.	s)
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Physiciar Medical Examin	-	Dolore			alieri							Month August 22,	Day 2009	Year 9	1010 hrs		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 200 9 tua Tansey John Jerome /Medical Sounty of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 2NB Himor nwotzsi If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex **Funeral** Vear) Min. 1 ₩ M 2 🗆 F Months Days Hours 1920 Massachusetts 89 June 28 Director 034-14-5212 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10h County show th and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Experies must be notified at 1 ☐Yes 21X No Directo Catonsville Baltimore <u>Maryland</u> 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 21228 Foxhall Farm Road United States 6019 Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WWII 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Orthopedics 5+ Physician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 2 John A. Tansey Helen Mahoney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21212 301 Cedarcroft Road, Baltimore, Maryland Health a John L. Tansey/ Son permit. Pages 1 and Department of Healt Important: If item 2' any injury or other once. Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) August 25 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Metro Crematory, Inc. Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 2009 22. Name and Address of Facility Cremation Society of Maryland, Inc. Signature of Funeral Service Licensee Amanda Heaston all 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Oaset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed physician and s the burlal-trans Due to (or as a consequence of): Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) Pregnant at time of death 1 □Yes Division of Vital Records, P.O. seen signed by the hould be detached 9 HInknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cale has autons perform 2 No 1 □ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28c. Injury at Work? 27. Manner of Beath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending s after death.

I Director: A

ed in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital within 24 hours a 29a. Certifier 1 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) 29c. License number 29b. Signature and tle of certifie address of or rson who completed caus of death (Item 23a) (Type Print) laid 32. Registrar's 31. Date filed (Month, Day, Year) State AUG 25 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2ď09 12:25 p^M August Ullrich Dorothy Eva /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Stella Maris Timonium Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🕅 F 216-05-5526 90 May 16, 1919 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 1 ☐ Yes 2 No Exacinst must be notified Director Md.Baltimore Timonium 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò 21093 USA 2300 Dulaney Valley Rd. items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 No Specify: White ģ 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, Its Medical once. 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Real Estate 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Kuchta Conrad J. Koerner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21206 Mr. Richard Ullrich/ Step<u>-Son</u> 3617 Mary Ave Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 D Burial 2 ☐ Cremation 3 ☐ Removal from State 8-29-09 4 Donation 5 Dother (Specify) Most Holy Redeemer Baltimore, Md. 22 Name and Address of Facility
Ruck Towson Funeral Home, Inc. 21. Signature of Funeral ervice/License 1050 York Rd. Towson, Md. 21204 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complicitions that caused to shock, or heart failure. List only one cause on the children children in the cause of the cause o hs that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final SECKE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) signed by the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l page 2 s autopsy performed? certificate 2**X** No 1 ☐ Yes 2 🗷 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital: Other: 42 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

10 V

12:25

AUGUST

DOROTHY

State Registrar

31. Date fil

29b. Signature and title of certifier

Medical

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 1:05 PM Marion В. Whiteford August 23 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MAYS CHAPEL BALTIMORE LORIEN TIMONIUM If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 M 2XX 212-10-3451 Jan 3, Mary Tand Director 92 1917 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show ral", or Items 23a or 28a-f shov Examiner must be notified at Director MD Baltimore Timonium 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 12230 Roundwood Road "natural", or items 23a 21093 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 X Married timore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced ear or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Monce. 11 Clerical Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William R. Bosley Alice Garrett 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Edwards / Daughter 6919 S. Sentinel Lane York, PA 17403 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/27/2009 Woodlawn Cemetery Baltimore, Maryland E. 21. Signature of Funeral Service Li 22. Name and Address of Facility Towson, Maryland Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part1. Enter the disease, or complications the caused the shock, or heart failure. List only one of the one each line. Approximate Interval Between Onset and Death caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** omplications disease or condition resulting in death) eews /Medical Due to Wr as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and Due to (or as a consequence of): physician Physician/Medical attending properties for use as 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 ₽No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 5 Pending investigation 1 🗹 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760. n 24 hours after death.

Ie Funeral Director: A pletely filled in by the fu within 24

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State Registrar

Medical

29a. Certifier (Check only one)

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 🗹 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

57,

N. CHARLES 82. Registrar's Sig

■ Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, &

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Please Type or Print in Black Indelible Ink, 25,00 , ws State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Lillie 2. Date of Death Wilson Year Month Physician 4:55 PaM 2009 08 16 LILLIE WILSON */Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE MD USA MANOR CATON If Under 1 Year | If Under 24 Hrs. | 8. | Months | Days | Hours | Min. | Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Months Days 249-26-3081 1 M 2 KF 88 Yrs. 11311 arolina South Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show ä 1 Nes 2 No Baltimore ns 23a or 28a-f sl must be notified Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 21230 S. care items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 'natural', or iten dical Examiner 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify: Black 1 Newer Married 2 Married 1□Yes 2□No Baltimore, Maryland 21215-0036 Specify: Completed by 3 ₩idowed 4 Divorced Ith and Mental Hygiene.
27 Is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Grace Endd Frank Eadd ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hubbard S Maryland -dangs imore Health tem 27 I Julia other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Department of H Important: If Ite any Injury or ot 3 ☐Removal from State 1 Burial 2 □ Cremation 109 andsdown Maryland Zion Cemeter 4 ☐ Donation 5 ☐ Other (Specify) permit. 22. Name and Address of Facility Ker Funeral 21. Signature of Fune al Service Licens Marviar more 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 16 **Physician** disease or condition resulting in death) /Medical Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequenc Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and is the burial-trans Division or Vital Records, P.O. Box 68760,义 resulting in death) Last Due to (or as a consequence of) Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 DUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes Ø No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) director Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Ursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After t 10 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: /
completely filled in by the f 2 Accident 6 ☐ Could not be 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

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31. Date filed (Month, Day,

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Frances Lillian Wayland Рм 23, 20:10 August 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Seasons Hospice & Palliative Care Inc. Baltimore Randallstown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 🔀 F 432 38 0246 Director Sept.21,1925 Arkansas Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at once. 1 ☐ Yes 2XCXNo Director Maryland Baltimore Essex 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 619 South Marlyn Avenue 21221 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc 1 Never Married 2 Married 1 □Yes 2 No Specify: White Specify If Yes, Give Year or Dates: \$ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) School Bus Company Aid 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Spurlock Emma White ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jeannette Campion (Daughter) 180 Walton Lane North East, Maryland 21901 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, Gardens Of Faith Cem. 8/27/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. SignAure of Funeral Service Licensee Bruzdziński Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Atheroschootic cardiovascular disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Year Month Day Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 4 Unknown 3 Probably 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) ent hospic Hospital: 2 🗆 No 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Katural 5 Pending 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

or Attending Physician: The law requires that the death certificate be executed Box 68760, Division of Vital Records, P.O. within 24 hours after death To the Funeral Director:

Baltimore, Maryland 21215-0036

Physician /Medical

Examiner

State Registrar 29b. Signature and title of certifier

15Rujapathol.M.D

N.S. Rajapakse, M.D

31. Date filed (Month, Day, Year) 32. Registrar's Signature 25

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N.S. Raigpakse, M.D. 2.5 Main St., Sui

29c. License number

D0057465

200, Reisterstown, MD. 21136

29d. Date signed (Month, Day, Year)

Mainst., Suite

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** \mathbf{P}^{M} Judith Renee Wagner 22, 2009 5:35 August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Ivy Hall Geriatric Center Middle River If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 06/07/1941 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 😾 F 218-36-5729 68 Yrs. Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location "natural", or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2XXNo Maryland Baltimore Essex Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1203 "H" Handsworth Place U.S.A. 21221 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Specify: White 1 □Yes 2/CXNo Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 11 Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph E. Wagner , Jr. Ruth Conjour ೨ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3809 Hutchinson Road, Wilmington, Delaware 19808 Joseph Wagner (Brother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 ☐ Femoval from State Bayview Crematory, Inc. 08/24/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Eacility} Bruzdzinski Funeral Home, P.A. 1407 old Eastern Avenue, Essex, Maryland 21221 21. Signature of Funeral Service Consec 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) PULMONARY DISEASE Examiner MROHIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 □Yes 2 □No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 □Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Certification: To 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident 3 Suicide

or Attending Physician: The law requires that the death certificate be executed Box 68760, o ۵. Division of Vital Records, Jas certificate within 24 hours after deat To the Funeral Director:

To the Hospital

Baltimore, Maryland 21215-0036

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier

(Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 29b. Signature and title of certifier 10 D27188 8-24-09

Type, Print)
Malle Place Dundalle MD 21222

of death (Item 23a) (Type, Print)

State Registrar

Medical (

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Evelyn Bertha Williams MA81:1 19 2000 5 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A BALTIMOR If Under 1 Year 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Nov. 1, . Age (In yrs. last birthday) **Funeral** Year) 93**7** 1 M 2 X Days Hours 219-26-1854 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10b County 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the Modest Exercises must be notified at 1 X Yes 2 □ No N/A Director Baltimore Maryland 10e. Street and Number 10g. Citizen of What Country? 21223 USA 1047 Wilmington Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 TNo Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates: Specify: Completed by 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) s 1 and 2 should be filed within if Health and Mental Hygiene. Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ernest Mills, Sr. Evelyn Flock 2 19a Informant's Name/Relationship (Type. Print)
Diane Robinson, daughter 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State Zip Code) 1235 Greystone Rd. Baltimore, MD. 21227 permit. Pages 1 a
Department of He
Important: If Item
any Injury or othe 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Atlantic Crematory 08-26-09 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ambrose Funeral Home, I 1328 Sulphur Spring Rd. 21227 Arbutus, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** disease or condition resulting in death) herosuldat /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a sone squares off To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit Due to (or as a consequence of): Box 68760 If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 1 ☐ Yes 2 No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 1 🔲 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) roor canina 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Month **Physician** 11:58 A^M 08 19 2009 Aretha M Williams /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's Heartland Health Care Center Adelphi Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Min. 1 □ M 2 😿 F Months Hours 59Yrs Director 578-70-7837 05/03/1950 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygiene. m 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show 1 X Yes 2 □ No Funeral Director Prince George's Adelphi 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1801 Metzerott Rd 20783 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify Specify: Completed by 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Investigator/legal secretary years EEOC other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Lawrence Carter Dorothy Hensley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i Stephanie Williams/Daughter 3429 Holmead Pl. NW Washington DC 20010 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Pages 1 permit. Pages 1
Department of H
Important: If Ite
any injury or ot
once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 8-25-2009 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshall's Funeral Home 21. Signature of Funeral Service Licensee 4217 9th St NW Washington DC 20011 Approximate Interval Between Onset and Death 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** disease or condition resulting in death) Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-trar and Due to (or as a consequence of): Physician/Medical the attending phys 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2★★No 24a. Was an 2 XNo 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2™No Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work?

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, P.0. of Vital Records, Division after death filled in by within 24 hours a To the Funeral C

State

31. Date filed (Month, AUG 2 Day, Year) 5 200 2009

5 Pending

title of certifier

investigation

6 Could not be determined

1xXNaturai

3 Suicide

29a. Certifier

ical

2 Accident

4 Homicide

(Check only one)

29b. Signature apa

32. Registrar's Signature

and manner stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

1 💢 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 🗆 Yes

2 No

29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

D0060100

August 19, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tahmina K. Ahmed, M.D. 831 University Blvd East SIlver Spring, Md.

৭ চ

Injury

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 200^{Year} Day **Physician** Althea Amanda Weikert Aug 21 3:00 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Look About Manor Carroll Westminster If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1-11-1921 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) **Funeral** Months Hours 1□M 2 F Days 203-10-6642 88 Pennsylvania Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryle Department of Health and Mental Hyglene.
Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any njury or other traumatic event, the Medical Examinat must be notified at once. MD Carroll Westminster 1 ☐ Yes 2 X No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1510 Stone Rd. 21158 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: white Specify: þ 3₺ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Waitress Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be A. Arthur Sponseller Effie Dayhoff 19a. Informant's Name/Relationship *(Type. Print)* Phyllis W. Egger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baer Ave., Hanover, PA 17331 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 8-26-2009|Hanover, PA Rest Haven Cem. 4 ☐ Donation 5 ☐ Other (Specify)

21. Sign: ture of preparal Service License 22. Name and Address of Facility Fletcher Funeral Home, PA eral Service Licensee 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Multi infarct Dementia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncerlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): sician and burial-transit law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒No Month Day Year 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ੬ icate has been sig r, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed Hypertension 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No <u>Diabetes II</u> 1 ∐ Yes 2 X No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 → Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident

Box 68760, P.0. Division of Vital Records, r death.

spital or Attendi nours after death. neral Director: A / filled in by the fu To the Hospital of within 24 hours af To the Funeral Discompletely filled in

20

State

30. Name and address of person who completed of Philip

6 ☐ Could not be

determined

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and the of certifie

AUG 25 2009

D33699

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29d. Date signed (Month, Day, Year)

8-24-2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

ause of death (Item 23a) (Type, Print)

Ruzbarsky 125 Airport Dr., Suite 34 Westminster, MD 21157 31. Date filed (Month, Day, Year) 32. Registrar's Signature

🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** onal М 2009 1:19 P /Medical August 19. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 X M 2 □ F Yrs. Director 11, 1966 | Maryland 219-82-0371 Usual Residence of Decedent with the Maryland show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 🔀 No Directo Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7803 B & A Blvd. 21060 United States Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2X No ₽ Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A h and Mental Hygie 8 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) Be Donald F. Winters Janet Marie Durm ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Mae Gudd / Aunt 920 Pine Rd.; Glen Burnie, MD 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ faurial 2 反 Cremation 3 ☐ Removal from State 4 ☐ Onation 5 ☐ Other (Specify) Aug. 22, 2009 Catonsville, Maryland Metro Crematory 21. Signature of Funeral Ser 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home, P.A. 459 421 Crain Hwy. SE; Glen Burnie, MD 21061 23a. Part I: Enter the disease, or official that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** minulla disease or condition resulting in death) ulmona /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed physician and the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ò Im munodeticieny 20 No 3 Probably 4 Unknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2001No certificate of Vital 1 ☐ Yes Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ inpatient 2 ☐ ER/Outpatient DOA Certification: To this After thi funeral o 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? Division 1. Natural 2 ☐ Accident 5 Pending Injury death. investigation 1 ☐ Yes 2 ☐ No Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours aft

To the Funeral Di

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 20/09 1)0033296 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Glen Burnie, Md. 21061

DHMH 17 Rev 1/2001

State Registrar Neil Padgett

31. Date filed (Month, Day, Year)

7711 Quarterfield Road

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Oswald George Addison, Sr. 5,2009 19US4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4516 Kinmount Road Prince George Lanham 3irthpiac Country) DC 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 □ F 84 578-20-8950 Yrs Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 11☑Yes 2☐No Maryland Prince George Lanham 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20706 United States 4516 Kinmount Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 1 ☐ Never Married 2 🙀 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Specify: African 3 ☐ Widowed 4 ☐ Divorced American 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Draftsman Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Thomas Addison Arizona H. Fraction 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Valerie Daniel/ Daughter 10463 Campus Way South Upper Marlboro, Md. 20774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 8/17/09 Maryland Veterans Cheltenham, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign sture of Funeral Service Lice 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Rd. NE Washington, DC 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CONGESTIVE CARDIOMYOPATHY years ATHEROSCLEROTIC HEART DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? metastatic concer 2XNo 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 □ Yes 3 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No 2 ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

/Medical Examiner or Attending Physician: The law requires that the death certificate be executed and physician ar s the burial-to Division of Vital Records, P.O. Box 68760, the attending phase the signed by peen has funeral director, this After t s after death filled in by the

Physician

/Medical

Examiner

Funeral

Director

show

ir than "natural", or items 23a or 28a-f sho

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Physician

Pages 1 and 2

death

Baltimore, Maryland 21215-0

Directo

Funeral

Be Completed by

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Examiner

by Physician/Medical

Completed

Be

Certification: To within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) nd title of cert 022780 500 Creenway Ctr VI. Greenbelt, MD 20770 of person who completed cause of death (Item 23a) (Type, Print) Schissler MI State Registrar DHMH 17 Rev 1/2001

		Please T	ype or Print in Bla State of Maryland						·.
	-	State Registrar		Cert	tificate of D	Death	F	Reg. No.	9 27 147
Physicia	n	Decedent's Name (First, Middle, Last) DATED	AVERY				Date of Dea Month	Day Yea	
/Medica	al .	DAVID			4h City Town or	Location of Doath	AUGUST	9 2009 4c. County of D	9:05A
Examine	er	4a. Facility Name (If not institution, give s			4b. City, Town, or SILVER			MONTGO	
uneral		HOLY CROSS HOSP 5. Social Security Number 6. Sex	7. Age (In yrs. las	t birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birtl (Month, Day	1 9.	Birthplace (State or Foreign Country)
irector		577-54-0578 Usual Residence of Decedent	M 2□F 68	Yrs.	Months Days	Hours Min.	FEB 28		ORTH CAROLINA
show	ō	10a. State 10b. County MD PRINCE GE		Town or Loc	ation HEIGHTS				10d. Inside City Limits 1XYes 2 □ No
or 28a-	Director	10e. Street and Number		RIOI	10f. Zip Code 20747	7		10g. Citizen of What	Country?
s 23a		1800 FOREST PAR		140.14			if- Van ar Na	USA AA Bass A	movinen Indian
or items	by Funeral	1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☆Yes 2 □ NoARNY If Yes, Give	lf lf	/as Decedent of His Yes, specify Cubar □Yes 2∏, No	spanic Origin? (Sp n, Mexican, Puerto Specify:	Rican, etc.)	Specify:	merican Indian, /hite, etc. BLACK
tural'	ed b	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates:	16a. Decede	ent's Usual Occupa	ation		16b. Kind of Busine	ess/Industry
Important: If them 27 is an enough of the "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evanding country of other traumatic event, the Medical Evanding country or other traumatic events.	Completed	(Specify only highest grade		(Give k life. D	ind of work done d O NOT use retired) STERED N	luring most of work)	ing	PRIVATE	
d other event, t	Be C	17. Father's Name (First, Middle, Last)						Maiden Surname)	
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7 Is n traur		19a. Informant's Name/Relationship (Ty)						er, City or Town, State ICT HEIGH	
other	ł	BERNICE_AVERY/V 20a. Method of Disposition			ition (Name of atory or other place		Date	20c. Location - City	
int: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State MD	VETER	ANS CEME	TERÝ 8/17			M, MARYLAND
y Ince		21. Signature of Funeral Service License	96	22.	Name and Addres	ss of Facility	J. B. JE	NKINS FUN	ERAL HOME
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		23a. Part 1. Enter the disease, or complishock, or heart failure. List only or	ne cause on each line.		r the mode of dying	g, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
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æ <u>-</u>	- 1	resulting in death) cast	Due to (or as a consequent	nce ot):					
physicia s the bur	dic							-	
by the attending p	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea 9 ☐ Unknown	eath 3 🗌	Ectopic pregnancy Other (specify)	у		23d. Date of Month	delivery Day Year
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Director	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	et, factory, office		28f. Location (3 City or Tox		or Rural Route Number,
	Medical C	29a. Certifier 1 CertifyIng Physical Check only one) 2 Medical Exami	sician: To the best of my knowl ner: On the basis of examination and manner stated.	edge, death on and/or inv	occurred at the tir	me, date and place pinion, death occu	e, and due to the rred at the time,	cause(s) and mann date and place, and	er as stated. due to the cause(s)
Fo the	Mec	29b. Signature and title of certifier	and married stated.		29c. License	e number		29d. Date signed (A	Month, Day, Year)
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2		30. Name and address of person who co	Impleted cause of death (Item 2 14 / 5 32. Register's Signatur	23a) (Type, F	Print)	olen Ro	ad 50	S MD á	0910
Sta	te	31. Date filed (Month, Day, Yaar)	32. Registur's Signatu	"Ked	V: 031		1	THE CO.	1 10

DHMH 17 Rev 1/2001

			For	State of	of Maryl				d Mental Hy	giene			
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	/Medic		Ruth Iren						August		.009	3:55	P M
	Examin	er	4a. Facility Name (If not institution	_	ımber)		4b. City, Town, o		Death	4c. County			
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	how at		10a. State 10b. County			. City, Town or Lo					10	0d. Inside C	ity Limits 2 X No
	e Ma ta-f s	당	Maryland Washi	ngton	В	oonsboro)						ZINO
	or 28	Dire	10e. Street and Number				10f. Zip Code			10g. Citizen of V		iry?	
	ath w	Funeral Director	6527 King Road	T			21713		0.40	U.S.	A. e - America	on Indian	
	er de Items	nue	11. Marital Status 1 ☐ Never Married 2 ☐ Marr	12. Was Dec		in U.S. 13.	If Yes, specify Cub	an, Mexican, F	n? (Specify Yes or No Puerto Rican, etc.)	Blac	k, White, e		
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2-003p	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show dical Examiner must be notified at		15. Deceden				dent's Usual Occu		formation m	16b. Kind of Bu	siness/Ind	dustry	
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n 0	ding Phys h. After this funeral dir		27. Manner of Death 1 ☐ Natural 5 ☐ Pendir	/8.60	e of Injury onth, Day Ye	ar) 28b. Time o	of 28c. Inju	ury at ork?	28d. Describe	how injury occur	red		
<u>0</u>	eath. or: A	Certification:	2 Accident investi	gation				Yes 2□No					
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifyii (Check only 2 Medical one)	Examiner: On the	basis of exa basis of exa unner stated,	inination and/or i	nvestigation, in my	opinion, death	occurred at the time	, date and place,	and due to	o the cause	(s)
	o the	Mec	29b. Signature and title of certific	17	11	<u></u>	29c. Licer	se number		29d. Date signe	ed (Month,	Day, Year)	
l	PSPÖ) June	1/1/	VI		Nam	57285	5	8/13	s/ zev	q	
			30. Name and address of person	who completed car	use of death	(Item 23a) (Type		ו	t	,		•	
2	4-6		a. Koilpillai	24	N. Wa	lnut s	1	OZ H	agerstown	MD	2176	fo	
	Sta	ate	31. Date filed (Month, Day, Year)	3 2000 32.	Registrar's	Signature		•)	(,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 7:07AM Lawrence Preston Ambrose 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Washington Hagerstown Washington County Hospital If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday) Voor 1 🗆 M 2 🗆 F 80 Jan 16, 1929 215-26-1205 Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1X Yes 2 No Marvland | Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 1416 Hamilton Blvd. 21742 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2 📉 No Specify. Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Engineer Hydraulics & Pneumatics 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Wesley Ambrose Emma Elizabeth Mullenix 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean E. Ambrose/Wife 1416 Hamilton Blvd., Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 8/13/2009 Rest Haven Cemetery Hagerstown, MD 4 Dopation 5 Dother (Specify) 21. Signal re of Funeral Service Licens 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final tdenucarchuma ONE Year disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) □Yes 2□No 9 Unknown countributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 □ Yes Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 1 ☐Yes 2 ☐ No 1 ☐ Yes 21

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Completed

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Funeral

Director

28a-f show

death with

7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Evantinat must be notified at

filed within 72 hours after of Hygiene.

12 should be filed with and Mental Hygier 7 is marked other th

permit. Pages 1 and 2 st Department of Health an Important: If Item 27 is r any Injury or other traur

3altimore, Maryland 21215-0036

Examiner Physician/Medical

burial-tran physician use as the attending p for use as signed by the a should has been page 2 s this certificate

requires that the death certificate be executed

Box 68760,

P.O. I

Records,

Division of Vital

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Medical

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

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Certification: To	1 Yes 2 N	0
= 1	27. Mann of Death	
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ij	3 Suicide	6 Could
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1 U atural 5 Pending investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide

4 Homicide 29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Hospital:

1 Dipatient 28a. Date of Injury (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA

28b. Time of

1 ☐ Yes 2 □ No

28c. Injury at Work?

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

determined

3H-2

Box 68760 P.O. Division of Vital Records,

To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician for use as the buria within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Funeral

Director

28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marical Examinal must be notified at

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

State Registrar

Medical

(Check only one)

29b. Signature and title of certifier

D0062435

1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sayed Elsayyad 10110 Molecular Dr. Rockville MD 20850

31. Date filed (Month, Day, Year)

AUG 11 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State AMEND#18perFH8/11/09, EMW, McCo Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 2009 Rose B. Alligood August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Living 4b. City, Town, or Location of Death Examiner Silver Spring
If Under 1 Year | If Under 24 Hrs. Montgomery Alfred House Eldercare Assisted Birthplace (State or Foreign Country) 5. Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Days Hours 245-10-0999 1 □ M 2 🗓 F North Carolina 08/08/1918 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State ed other than "natural", or items 23a or 28a-f show event, it a Medical Examinar must be notified at 1 ⊈Yes 2 ☐ No Director MD Montgomery Silver Spring 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20906 United States 3270 Gleneagles Dr. Building 67 #2B Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21 No Specify: Specify:White ģ 3 1 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, It a Me Elementary/Secondary (0-12) College (1-4or 5+) Tax Receptionist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Latzette Goodson James Sydney Hallman ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3528 Hamlet Pl. Chevy Chase, MD 20815 Jeffrey S. Harwood / Nephew 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 08/14/2009 Brentwood, MD Ft. Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service Licensee 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 10 Months Oral Cavity Squamous Cell Carcinoma **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, ner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami sician and burial-trans Due to (or as a consequence of). attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ♣ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Chronic Renal Insufficiency Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 DNo 1 ☐ Yes 2 ☐ No 1 🗆 Yes Assisted 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: $_{4}\square$ Nursing Home $_{5}\square$ Residence $_{6}\boxtimes$ Other (Specify Living Hospital: 1 ☐ Yes 2 🖾 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 1 X Natural 5 Pending investigation 1 □Yes 2 □ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division of Vital Records, P.O. Box 68760, cate has been signed by the page 2 should be detached Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 10

certificate be executed

28a-f show

72 hours after death with

Baltimore, Maryland 21215-0036

James A. Rossi 31. Date filed (Month, Day, Year) State Registrar

Medical

29a, Certifier

29b. Signature and title of certifier

AUG 11

3305 Leisure World Blvd., Silver Spring, MD Registrar's Signati

an mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D24543

29d. Date signed (Month, Day, Year)

August 7, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-06127 State of Maryland / Department of Health and Mental Hygiene Ellen Becton Certificate of Death 1- For State Reg. No Registrar 2. Date of Death Time of Death Decedent's Name (First, Middle,Last) Physician/ Month Year 2045 hrs Medical Examiner August 5, 2009 ELLEN BECTON c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Montgomery Takoma Park Washington Adevntist Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Country Months Days Director NC 18, 1924 М 2 X F 85 Jan. 237-62-6108 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County Yes 2 X No 23a or 28a-f show a notified at once. MD Prince Georges Temple Hills death with the Maryland 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number 20748 USA ā 6908 Kingston Dr. 14. Race - American Indian. Black. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status 12. Was Decedent Ever in U.S. White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married Married 2 X No Yes Yes 2 X No specify: Specify: Black 4 X Divorced If Yes, Give Year nours after Widowed <u>ج</u> 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 F nent of Health and Mental Hygiene. ant: If item 27 is marked other than "1" or other traumatic event, the Medical E Baltimore, MD 21215-0036 WC Smith Company 8th Elevator Operator 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Oberry Smith Lolettie Hilliard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ٩ 1117 Whaler Pl. SE 20032 Carolyn Becton-Daughter Washington, DC 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State permit Pages
Department of
Important: I Becton Memorial Gardens 8-15-09 Magnolia, NC Other Specify: Donation 5 ²² Name and Address of Eacility Marshall's Funeral Home of Maryland 21. Signature of Funeral Service Dicensee Suitland, Md. 4308 Suitland Rd. 20746 Approximate Interval 23a, Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. /Medical Death a. Hypertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease ;amine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical UNPENDED AMENDED attending physician or use as the burial To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 i signed by the atte Yes 2 ✓ No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. ģ 1 Yes 2 No 3 Probably 4 V Unknown Septicemia, diabetes mellitus Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed' death? certificate has 1 🗸 Yes ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? Hospital: 1 V Inpatient Nursing Home 5 Residence 6 Other: DOA ER/Outpatient 3 2 this 1 🗸 Yes No 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury Certification: 1 V Natural Yes 2 No Pending 2 Investigation Accident 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide determined Homicide

n 24 hours after death he Funeral Director: After th

State 31. Date filed (Month, Day, 1) istrar Registrar AFE O A DAIL

29b. Signature and title of certifier

Zabiullah Ali, M.D.

29a. Certifier 1

Medical

111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner 32. Registrar's Schature

and manner stated

30. Name and address of person who completed cause of death (Item 23a)

ORIGINAL

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

August 6, 2009

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

_	_1	For State Registrar			ficate of		Mental Hyg	Reg. No.	009	271	53
		. Decedent's Name (First, Middle, La	ist)				2. Date of Dea Month	ath Day	Year	3. Time of	Death
ciar Iica		Verna M. Brow	wn				August		2009	0911	М
ine	233	a. Fecility Name (If not institution, given	ve street and number)		b. City, Town, o	r Location of De	ath		County of Deeth		
		Prince George's			Chever		re 0 D (D) a)		ince Ge		
at or			Sex 7. Age (In yrs. 1 ☐ M 2 ☐ F	Yrs	Months Days	Hours Mi	n. (Month, Da)			hplace (State o untry)	
		79-26-1678 Jsual Residence of Decedent	8.	3			5/18/1	926	Con	nectic	1t
		0a. State 10b. County	10c. Ci	ty, Town or Loca	tion					10d. Inside C	ity Limits
\$	ō i	Maryland Prince (George's Sea	t Pleasa	int					1 _₹ Yes	2 🗍 No
Director	1	0e. Street and Number			10f. Zip Code			10g. Citize	en of What Co	untry?	
		836 Booker Drive			207	43		Į	JSA		
Finorei	1	1. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13. Wa	as Decedent of h	lispanic Origin?	(Specify Yes or No- erto Rican, etc.)	- 1-	4. Race - Ame Black, White		
ŭ	2	1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give	1	Yes 2↓ No	Specify:		1		Black	
	a b	3 Widowed 4 Divorced	Year or Dates:								
ato.	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Give kii	nt's Usual Occup nd of work done	during most of w	vorking	16b. Kin	d of Business/	Industry	
1	E	Elementary/Secondary (0-12)	College (1-4or 5+)		NOT use retire			D		- C T - L	
		17. Father's Name (First, Middle, Lasi	3	OIII	Lce Mana		ame (First, Middle,		rtment	or Lab	or
a	n	Vernon McFarland	•/				ie Missou				
ř	=	19a. Informant's Name/Relationship	(Tune Print)	10h Mailing	Address /Street		Rural Route Numbe			in Code)	
Ĺ											
		Nathan H. Brown,	20b.	Place of Disposit	ion (Name of		nt Pleasa Date	20c. Loc	ation - City or	Town, State	
		1 ☑ Burial 2 ☐ Cremation 3	Hemoval from State	cemetery, crema			13/2009				
		*4 □Donation 5 □ Other (Speci 21. Signature of Funeral) Service Liefe					t. Lincol				
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	+	23a. Part1. Enter the disease, or con	nolications that caused the dea						, ,,	Approxima	te
	aminer	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Fatal Ca Due to (or as a conse b. Diabetes Due to (or as a conse c. Hyperten Due to (or as a conse d. Respirat	quence of): quence of): sion quence of):		<u>.a</u>					
100	<u></u>	IF CELLAL E									
Alacioi.	-	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 XNo	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3□E	ictopic pregnanc Other (specify) _	у		2	3d. Date of del Month		Year
DAY.	<u> </u>	9 Unknown		-						4	d 15 0
3	ر م	Part II. Other significant conditions	contributing to death but not re	sutting in the und	erlying cause gi	ven in Part I.			se contribute to		
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•	0 1	25. Was case referred to medical examiner?							Other /Sne	city)	
0	lo Be	examiner? 1 ☐ Yes 2 ☐ XNo	Hospital: 1 西Inpatient 2 [] ER/Outpatient	3□ DOA Ott	nac	Home 5 ☐ Resid	dence 6	Clother (Ope		
TOBO	10 26	examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 本Inpatient 2 [28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	3 DOA Ott	ner: 4 ☐ Nursin					
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Toba	lo Be	examiner? 1 Yes 2 ZNo 27. Manner of Death 1 Natural 5 Pending 2 Accident investigatic 3 Suicide 6 Could not determined	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At I building, etc. (Special Control of the Contr	28b. Time of Injury	28c. Inju Wo M 1 =	ner: 4 □ Nursing ry at rk? Yes 2 □ No	28f. Location (S	how injury Street and wn, State)	occurred Number or Ru		n <i>ber</i> ,
Cortification: To Be	Certification: To Be	examiner? 1 Yes 2 XNo 27. Manner of Death 1 XNatural 5 Pending investigatic 3 Suicide 6 Could not determined 4 Homicide 1 Certifying P	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At I	28b. Time of Injury	28c. Inju Wo M 1 == 20t, factory, office	ner: 4 Nursing ry at rk? Yes 2 No	28d. Describe I 28f. Location (City or Tov	Street and wn, State)	Occurred Number or Ru and manner as	s stated.	
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odical Cartification: To Do	Medical Certification: 10 Be	examiner? 1	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At I building, etc. (Specials: To the best of my kn miner: On the basis of examinand many of stated.	28b. Time of Injury nome, farm, stree nowledge, death of ation and/or investigation	28c. Inju Wo 1 Control of the transfer of the	ner: 4 Nursing ry at rk? Yes 2 No rme, date and pla opinion, death or	28d. Describe 1 28f. Location (Sale of the course of the time,	Street and wn, State) cause(s) added and	occurred Number or Re and manner as place, and due e signed (Monte	s stated. to the cause(h, Day, Year)	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** М AUGUST 8, 2009 1640 JIMMIE HEYWARD BOYD /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner WASHINGTON ADVENTIST HOSPITAL Takoma Park MONTGOMERY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min. 13亿 M 2□ F 4/12/1929 Director 227-36-7529 80 Bracey, VA Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, tra Medical Exprairer rust be rediffed at once. 1 Yes 2 □ No Prince George's Marland Oxon_Hill 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20745 United States 1006 Elkhart Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. Specify: Black ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 <u>Investigator</u> Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Benjamin Boyd Ethel Boyd ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1006 Elkhart Street Oxon Hill, Maryland 20745 Ethel B. Boyd / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 8/12/2009 Metropolitan Alexandria, VA 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Funeral Service Licensce 5538 Marlboro Pike Forestville, Maryland 20747 Tweed MOIOS 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) P.O. Box 68760, ned by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed by 1 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 2 □ No 1 ☐Yes 2 X No 1 Yes Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔼 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 □Yes 2 □ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

31. Date filed (Month. Day, Year, State AUG 11 Registrar

29b. Signature and title

certifie



29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Day Month A^M AUGUST 10, 2009 9:30 CLARENCE N. BLACK 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death PRINCE GEORGE'S CLINTON NURSING HOME CLINTON 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 5. Social Security Number Days Hours 1 XM 2 □ F 9/3/1941 579-52-9852 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1XYes 2 □ No Clinton Marvland Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20735 12031 Birchview Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∏ Yes 2 ☑ If Yes, Give Year or Dates: 2⊠ No 1 Never Married 2 Married Specify: Black 1 ☐ Yes 21 No 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Printing Elementary/Secondary (0-12) College (1-4or 5+) Government Book Binder Office 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ann Gray Rose Herman Black 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4226 7th Street NW #4 Washington, D.C. 20011 Donald Best / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 8/13/2009 4 Donation 5 Other (Specify) Metropolitan Alexandria, VA 22. Name and Address of Facilit Pope Funeral Homes, P.A. 21. Signature of Funeral Service Licen 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PANCREATIC CANCER disease or condition

Physician /Medical Examiner

injury or Department of Important: If any injury or once.

Physician

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

"natural",

Pages 1 and 2 should be filment of Health and Mental Heart: If Item 27 is marked ott

Directo

þ

Completed

Be

the Maryland

filed within 72 hours after death with

Baltimore, Maryland 21215-0036

/Medical

10a State

Examiner Medical Certification: To Be Completed by Physician/Medical within 24 hours after death

To the Funeral Director:
completely filled in by the

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

resulting in dealiny	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Line Underlying Cause (Disease or injury	b	
Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequence of):	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1	23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown
		24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No
25. Was case referred to medical	26. Place of Dea	th (Check only one)
examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Hospital Hos	ome 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injury 28b. Time of (Month, Day Year) 28b. Time of Unjury 28c. Injury at Work?	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not to determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 Certifying P	hysician: To the best of my knowledge, death occurred at the time, date and place iminer: On the basis of examination and/or investigation, in my opinion, death occurred manner stated.	, and due to the cause(s) and manner as stated. Irred at the time, date and place, and due to the cause(s)

29c. License number

11701 Livingston Road Suite 101 Fort Washington, MD 20744

D45365

29d. Date signed (Month, Day, Year)

8/11/2009

DHMH 17 Rev 1/2001

3

State

Registrar

29b. Signature and title of certifier

Michael Sidarous, 31. Date filed (Month. Dav. Year.

AUG 1 1 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible.
State of Maryland / Department of H	lealth and Mental Hygiene

			For State Of Final St	nai yianu / D		ificate of L			g. No.	009	27155
			Decedent's Name (First, Middle, Last)				-	2. Date of Death	Day	Year	3. Time of Death
	Physicia /Medic	al	Anthony J. Bello					August	7	2009	658AM
	Examin		4a. Facility Name (If not institution, give street and number	er)	10	4b. City, Town, or	Location of Death			inty of Death	
,,,,,,,			Doctor's Community Hospi		()	Lanham If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Pri	nce Geo	orge's
	Funeral Director		578-22-2750 t€ M 2□ F	Age (In yrs. last birt	Yrs.	Months Days	Hours Min.	(Month, Day, 4/21/192		Coun	ington, DC
	land		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Loca	ition				1	0d. Inside City Limits
	Mary -f sh	tor	Maryland Prince George's	Lanham							1 TyYes 2 □ No
	or 28a	Director	10e. Street and Number		·	10f. Zip Code		10	g. Citizen	of What Cour	ntry?
	th wit		5612 Ellerbie Street			20706			JSA		
	tems rems	Funeral	11. Marital Status 12. Was Decede Armed Force	s?	13. W	as Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		Race - Americ Black, White,	
36	or i	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Date	10/6	1	□Yes 2☐No	Specify:		Sp	ecify: Whi	te
9	filed within 72 hours after death with the Maryland Hygene. other than "natural", or items 23a or 28a-f show ent, the Medical Examinat must be notified at	ted	15. Decedent's Education			ent's Usual Occupa			6b. Kind	of Business/In	dustry
212	thin 73 e. an "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-40)	r 5+)	life. D	O NOT use retired	luring most of work)	mg			
Maryland 21215-0036	ed wil	Con	12	Dra	afts	man Engi	neer Des: 18. Mother's Nam	igner	NAS	A, God	dard
and	ntal F ed otl	Be	17. Father's Name (First, Middle, Last)					Clements		,,,,,,,	
Ĕ	hould od Me mark matlo	မ	Vincenzo Bello 19a. Informant's Name/Relationship (Type. Print)	19b.	. Mailing	Address (Street a	and Number or Rui			own, State, Zip	Code)
S S	nd 2 sulth ar		Stephanie Bello - Wife				St., Lan		2070		
ē,	s 1 ar		20a. Method of Disposition	20b. Place of		ition (Name of atory or other plac			20c. Locat	ion - City or To	own, State
<u>=</u>	Page nent c ant; If ury or		1 XBurial 2 ☐ Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)	te I	nco1	n Cemete	r 8/12			ood, M	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensea	le			ss of Facility Ft . nsburg Re				me 20722
			23a. Part1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each	sed the death. Do r	not ente	r the mode of dyin	g, such as cardiac	or respiratory arre	est,	The state of the s	Approximate Interval Between
	Physician	ř	Immediate Cours /Final	Cardia A	Arrv	hthmia				4	Onset and Death
	/Medical	resulting in death) Due to (or as a consequence of): Convestive Heart Failure									
	Examiner										
	ted nsit	Examiner	cause. Enter Underlying	e Corone		rtory Di	00000				
	execu n and al-tra	Exar	that initiated events resulting in death) Last C. Due to (or	as a consequence		itery br	sease				
68760,	eath certificate be executed attending physician and for use as the burial-transit	edical	d. Hyper	tension							
	certifi nding use as		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outco						230	d. Date of deliv	very
P.O. Box	Attending Physician: The law requires that the death cer roteath. ector: After this certificate has been signed by the attendin by the funeral director, page 2 should be detached for use	Completed by Physician/M	in the part 12 months?	h 2□ Fetal death nt at time of death n		Other (specify)	y 			Month	Day Year
	that the de ned by the a detached f	Phy	Part II. Other significant conditions contributing to deal	h but not resulting in	n the un	derlying cause giv	en in Part I.	23e. Did tol	oacco use	contribute to	the cause of death?
ds,	w requires that s been signed t should be deta	d by	Diabetes Mellitis					1 □ Y€	es 2 🗆	No 3□ Pro	bably 4 2 Unknown
00	w req	lete	Hyper Lipidemia					24a. Was a		24b. Were aut	opsy findings available
æ	The la te has	шо						autops perforr 1 □ Yes	ned?	death?	ompletion of cause of 2 □No
<u>ta</u>	lan: 'rtifica	Be C	Periperal Vascular I 25. Was case referred to medical	1sease			26. Place of Dea	th (Check only on			
<u></u>	hysic his ce I direc		examiner? 1 ☐ Yes 2 🛱 No Hospital: 1 ☐ Ing	atient 2 ER/Ou			4 □ Nursing H	ome 5 Reside			ify)
n o	ing P	.i.o	I Litatulai 5 Literionig		Time of Injury	28c. Injur Worl	k?	28d. Describe ho	ow injury o	occurred	
sio	tend death. tor: / the fi	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e Place 0	Injury - At home, fa	arm etre		Yes 2□No	28f Location (S	troot and l	Number or Rui	ral Route Number,
Division of Vital Records,	after a	Certification: To		, etc. (Specify)	arm, oue	et, lactory, office		City or Town	n, State)		
	To the Hospital or Attending Physiclan: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier (Check only one) 29a. Certifying Physician: To the base one) Medical Examiner: On the base one)	is of examination at	e, death	occurred at the tivestigation, in my	me, date and place opinion, death occu	e, and due to the durred at the time, d	ause(s) a late and p	nd manner as lace, and due	stated. to the cause(s)
	To the within 2 To the comple	Mec	29b. Signature and title of certifier			29c. Licens	e number	2	9d. Date	signed (Month	, Day, Year)
	->-0		I thenat Jad	1		MDDO	1883		8-7	- 200	9
	10		30. Name and address of person who completed cause	of death (Item 23a)	(Type, I	Drint\					
12	_ 10		Hema P. YALLA 9470 A. 31. Date filed (Month, Day, Year) 32. Reg	NAPOLI J	R	D Suite	308 L	ANHAM	MD	207	0 6
	Sta Regista		AUG 1 1 2009 Chrons	istrar's Signature							

09-06061	
Katherine Buta	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

atherine Buta		- For State	Maryland /		tment of ificate of		id Mental H		ı. No.	200	9 2715
Physician	1/	egistrar 1. Decedent's Name (First, Middle,Last) Katherine Marie	Buta					2. Date of Death Month August 3, 2		Year	3. Time of Death 1800 hrs
Medical Examin		a. Facility Name (if not institution, give str			4	b. City, Town, o	r Location of Death		4c. Coul	nty of Death	
ş		Route 4 South and Upper Pir		()	t bladbalan	Lothian	ar If Under 24Hr	8 Date of Birth		Arundel	thplace (State or
Funeral Director			2 X F 57		st birthday) Yrs.	If Under 1 Ye Months Da		_		Foreig	
any	-	Usual Residence of Decedent 10a. State 10b. County	1	0c. City, 7	Town or Locati	on					10d. Inside City Limits 1 Yes 2 XX No
faryland	اِقِ	MD Calvert		Ow	ings	10f. Zip Code		10	a Citizen o	f What Cour	
ith the Maryland 23a or 28a-f sho notified at once.		10e. Street and Number 6700 Bayberry C	rossing			2073	6		-	S.A.	,
r death with	Funeral	1 Never Married 2 Married 1		ver in U.S	If Y	es, specify Cuba	ispanic Origin? (S an, Mexican, Puerto	pecify Yes or No- c Rican, etc.)	V	Race - Ameri Vhite, etc. _{rify:} Whit	ican Indian, Black,
urs afte tural",	3 X Wloowed 4 Divorced in the Store fair in the									of Business/	
16 n 72 hou nan "nai ical Ex								tired)	Educ	cation	1
-003 d withing giene.	Pradley But a /Son Office of Education 17. Father's Name (First, Middle, Last) Adolph Wallace Hoglund 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Fig. 19b. Mailing Address) 18. Mother's Name Rose D 19b. Mailing Address (Street and Number or Fig. 19b. Mailing Address) 19b. Mailing Address (Street and Number or Fig. 19b. Mailing Address)										
215 he file ental ly rrked o											
ID 2. 2 should and Mr 27 is me	ို	19a. Informant's Name/Relationship (Type Bradley Buta/Son	, Print)				eet and Number or y Crossii				
HOFE, MD ages 1 and 2 sho nt of Health and nt: If item 27 is other traumati		20a. Method of Disposition	Domewal from Stat			ition (Name of c		Date	20c. Local	tion - City or	Town, State
Baltimore, MD pernit. Pages I and 2 sho Department of Health and Important: If view 27 is injury or other traumaninjury or other traumani		4 Donation 5 Other Specify	/		e Crema	torv	08	/08/2009	_C1:	inton,	, MD
Baltimore, MI permit. Pages I and 2 s Department of Health a Important: If item 27 injury or other traum		21. Signatur of F neral Servic Geer ee 22. Name and Address of Facility Lee Funeral Home Calvers of Southern Md Blvd., Owings, MD 2									vert, P.A. 20736
Physician /Medical		23a. Part I. Enter the disease, or complica failure. List only one cause on each	ine.	he death.	Do not enter ti	ne mode of dyin	g, such as cardiac	or respiratory arre	est, shock, o	or heart	Approximate Interval Between Onset and Death
xaminer			ad Injuries to (or as a conse	quence of):						Death
	_	Sequentially list conditions, b If any, leading to immediate									-
	mine	cause. Enter Underlying Cause (Disease or injury that initiated								0	
ruted nd ransit	Physician/Medical Examiner	events resulting in death) Last d	e to (or as a conse	quence or):						
60, ate be evec hysician a	dica	UNPENDED	MENDED								
ox 68760, eath certificate be executed aftending physician and ourse as the burial - transition or use as the burial - transition.	M/Mg	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	e of pregn		etal death 3	Ectopic pregi	nancy	23d. Da Mor	ite of deliver ith	ry Day Year
Box 687 death certifice the attending p defor use as th	sicis	4 No. of No. C. Albinous	Pregnant at t	ime of dea	ath 5 Ot	her (Specify)					
that the d		Part II. Other significant conditions co		but not re	sulting in the	underlying causi	e given in Part I.				o the cause of death?
S, P.(ed by		<u> </u>					1 Yes - 24a. Was			obably 4 Unknown
Vital Records, sician: The law requii	Completed					-		autop			completion of cause of
tal Rec		25. Was case referred to medical				26.Pla	ice of Death (Chec		2 V No	1 Y	res 2 No
Vital	To Be	Turnania a a O	oital: 1 Inpatier	nt 2	ER/Outpatient		Other	sing Home 5	Residence	6 🗸 Oth	er: Scene
ing Ph		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injur (Month, Day, Ye Aug 3, 2009	y ear)	28b. Time of 1756 hrs	Injury 28c. Ir	njury at Work? Yes 2 ✔ No	28d. Describe Passenger i	now injury o	occurred to fixed	l object collision
Division spital or Attendi hours after death. neral Director:	Certification:	2 Accident Investigation	28e. Place of Inj	ury - At ho	ome, farm, stre	et, factory, offic				Number or R	Rural Route Number, City
Div Hospital o 24 hours afl Fimeral D	Certi	4 Homicide determined	(Specify) Maj					.1	h and Upp		Road, Lothian, MD
Division To the Hospital or Attend within 24 hours after death To the Fineral Director: completely filled in by the	Medical	29a. Certifier 1 Certifying Physician one) 2 Medical Examiner:O	n the basis of exam	knowledg nination ar	ge, death occu nd/or investiga	rred at the time, tion, in my opin	date and place, a ion, death occurred	nd due to the caus d at the time, date	se(s) and m and place,	anner as sta and due to t	ated. the cause(s)
To cor	Me	29b. Signature and title of certifier	d manner stated.				ense number		1		lonth, Day, Year)
		Tapiel Touth	all m	1		0.0	C.M.E.		Augus	t 4, 2009	
den 10		30. Name and address of person who cor Pamela E. Southall, MD	npleted cáuse of di ssistant Medi			1 Penn Stre	eet, Baltimore,	MD 21201			
Sta	ate										
Registi	ell	AUG II / ///	Kener		12. 12.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Bernard 8-6-2009 24 A^M Bell /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Southern Maryland Hospital Prince George Clinton
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) tate or Foreign 5. Social Security Number Funeral Days Hours Months 1**X** M 2□ F Yrs. Director 69 11-18-1939 Maryland 218-34-7341 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County show r than "natural", or items 23a or 28a-f show the Wedical Exercises out the redthed at 1XYes 2 No Directo Charles Bryantown Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a amp injury or other traumatic event, tre Medical Exercite and once. 6953 Leonardtown Rd 20617 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2€ No Baltimore, Maryland 21215-0036 Specify. Specify: Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Equipment Operator 12 Chaney Enterprise 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Bernard Bell Hawkins Sr. မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Leonardtown Rd, Bryantown Maryland20617 Odessa Bell / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 8/14/2009 Cheltenham MD MD Veterans Cem 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Vingral Service Licemee 22. Name and Address of Facility toy Adams Funeral Home PA Aquasco MD 20608 191 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** NEUMONI Sequentially list conditions, it is a production of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 Unknown Be Completed DISSASS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 Nio 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 📉 No Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VENEAT - \$ CAMAMON 7501 SUR NAT

32. Registrar's Signature

parks

SUR RATTS

29c. License number

3885

29d. Date signed (Month, Day, Year)

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death 1 6:02 M **Physician** 2004 Charles R. Butler Jr /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug 16 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) 972 Days Hours Maryland Months 1**™** M 2□ F 36 Yrs 218-88-8108 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 23a or 28a-f show Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a livelies Extuding the modified. 28a-f show 1 ☐ Yes 2 No Director Frederick Maryland Frederick 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? filed within 72 hours after death with I Hygiene. 6213 Quinn Rd. 21701 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify Specify: Black Yes. Give þ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Tile Setter Tile Company 12th O 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cythia Smith Charles R. Butler Sr ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Frederick, Md. 21701 6213 Quinn Rd. Cythia Jackson(Mother) 20c. Location - City or Town, State 20a. Method of Disposition 206 Anderph Displation (Name of certifiery, crematory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Cemetery 8-7-09 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) Miname Reaches of Scillisons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 Harry MO088 H. 800 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACQUIRED IMM UNE BEFICIENCY SYNDROM **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed burial-transi Exam and Due to (or as a consequence of) P.O. Box 68760 signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown cate has been signification of the category. Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 □Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 🗶 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Physician /Medical Examiner physician and the burial-transit

Physician

/Medical

Examiner

10a. State

Directo

Funeral

ģ

Completed

Be

Funeral

Director

filed within 72 hours after death with the Maryland Hygiene.

ther than "natural", or items 23a or 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evanther must be notified at

3altimore, Maryland 21215-0036

After this certificate has been signed by the attending p funeral director, page 2 should be detached for use as:

Division of Vital Records, P.O. Box 68760, death. nours after death. Hospital 6 24 hours a To the Hospital within 24 hours a To the Funeral L

29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINGH 31. Date filed (Month, Day, Year) State 2009 **AUG 10** Registrar DHMH 17 Rev 1/2001

Seruentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð Completed 25. Was case referred to medical Be 1 Yes 2 No Certification: To 27, Manner of Death Natural 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** LMER 9:30 AM ERWE 09 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Annapolis 322 Halsey Road If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 □ F New Jersey 11/18/1924 84 Director 144-14-6131 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State "natural", or items 23a or 28a-f show ofice! Examiner mast be notified at 1XXYes 2 No Maryland Anne Arundel Annapolis Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with USA 21401 322 Halsey Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 ▼Yes 2 No 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 WWII 1 ☐ Yes 2 🙀 No Specify: White Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) f Health and Mental Hygiene. Item 27 Is marked other than "natur other traumatic event, Its Madical 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ General Manager Electrical Contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Butterwei Kathryn Dodd ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 322 Halsey Road, annapolis, MD 21401 Evelyn Butterwei - Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of F
Important: If Ite
any Injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore Crematory 8/9/2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home, Inc 21. Signature of Funeral Service Licensee Mochin Wales 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Dein **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a nonsequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Exami attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 □Yes 2 □ No sate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 🗆 No 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? After (Month, Day, Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Y Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature

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ed cause of death (Item 23a) (Type, Prin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 5.054 M Robert Lee Burgee, Sr. 06057 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Doctor's Community Hospital Lanham 8. Date of Birth (Month, Day, Year)
NOV. 25, 1 9. Birthplace (State or Foreign Country)
Maryland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Hours 1 ☑ M 2 □ F Months 218-24-9254 79 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2X No Riverdale Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 20737 USA 6805 Furman Parkway 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒No 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Washington Gas Company Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Cora Spurrior Howard Burgee 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma L. Burgee / spouse 6805 Furman Parkway Riverdale, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/8/2009 Bayview Crematory Baltimore, MD 22. Name and Address of Facility Beall Funeral Home 21. Signature of Furjeral Service Licensee Bowie, MD 6512 NW Crain Hwy. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sersis Due to (or as a consequence of): 7 days Small Bowel Necrosis Due to (or as a consequence of) Bladder Cancer 2 weeks Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Vear Month 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

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After this

(To the Hospital or Attending Promin 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral

page 2 s has

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attending physician

Box 68760,

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Division of Vital Records,

Physician:

The law requires that the death certificate be

Physician

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Certification: To

Medical

MD

Funeral

Director

Department of Health and Mental Hygiene. Important: If item 27 is marked outher than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evarance must be notified at

Baltimore, Maryland 21215-0036

and 2 should be

/Medical

Sequentially list conditions, if any, leading to immediate cause. Little Underlying Cause (Disease or injury resulting in death) Last

IF FEMALE:

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atherosclerosis Hypoalguminemia

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed

2XXNo

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death

1 Natural

3 Suicide

29a, Certifier

2 Accident

4 Homicide

Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28h Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred

26. Place of Death (Check only one)

1 ☐ Yes

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1₺ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated. 29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

determined

29c. License number MBD 21043

29d. Date signed (Month, Day, Year) AUGUST 7, 2009

ddress of person who completed cause of death (Item 23a) (Type, Print)

PAKKWAY EKEENSELT, MD 20170 7205 HANDVELL 6211.ALD LIN

State Registrar

31. Date filed (Month)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2009 Year Physician 5:00 AM August 7 Anita L. Boyer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cecil Port Deposit 19 Linton Run Road 8. Date of Birth (Month, Day, Year 05/23/1917 9. Birthplace (State or Foreign Country)
Pennsylvania If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday Funeral Days Hours 1 □ M 2 1 □ F 92 201-03-6664 Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylani Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modeal Experiment and the nutified at once. 10c. City, Town or Location 1 ☐ Yes 2 ☐ No Director Port Deposit Cecil 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21904 U.S.A. 19 Linton Run Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕱 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🕱 No Specify þ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home. Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward James Gillbee Anna Harmar 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Edward M. Boyer (Son) 23 4th Avenue. Narrowsburg. NY 12764 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State R.A. Ferris & Co. Inc. 08/10/2009 West Chester, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Zellman Funeral Home, P.A. MD 21078 123 S. Washington St., Havre de Grace. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a conseque ce of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed and burial-tran Due to (or as a consequence of) Box 68760, attending physician Physician/Medical as the nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown P.O.1 the detached 9 Unknown signed by it 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 ☐ Yes 2 No 1 □Yes 2 No Hospital or Attending Physician; 74 hours after death.
Funeral Director: After this certifica director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 ☐ Homicide within 24 hours a To the Funeral C 1 x ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Pay, Year) 29c. License number 29b. Signature

State

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

AUG 10

Back

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Ma For State Registrar		artment of Health and f ctificate of Death	vientai Hygie Reg.							
		1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year 3. Time of Death						
Physic /Med		Herbert N. Blackman			August 8							
Exami		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death	1	4c. County of Death						
t .		7004 Wilson Lane 5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	Bethesda If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Montgomery 9. Birthplace (State or Foreign						
Funera Directo	_	220-42-1536 1\(\frac{1}{3}\)M 2□ F	Yrs.	Months Days Hours Min.	12/20/19	Par) Country) New York						
		Usual Residence of Decedent				10d. Inside City Limits						
arylan show	<u> </u>	10a. State 10b. County	10c. City, Town or Lo			1 ⊠Yes 2 □ No						
he Ma 28a-f	ectc	MD Montgomery 10e. Street and Number	Decliesa	10f. Zip Code	10g	. Citizen of What Country?						
ire, Maryland ZIZIO-0030 s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exp. vir or items 23a or 28a-f show	Funeral Director	7004 Wilson Lane		20817		nited States						
death ms 23	nera	11. Marital Status 12. Was Decedent E Armed Forces?	ever in U.S. 13.	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.						
after or ite		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ N	lo	1 □Yes 2 □ No Specify:		Specify: White						
ural",	d by	3 ■ Widowed 4 □ Divorced Year or Dates:	10.0	dent's Usual Occupation	16	ib. Kind of Business/Industry						
n 72 h	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5-	(Give	dent's Usual Occupation kind of work done during most of wor DO NOT use retired)	rking							
Z I Z I 3-UU30 d within 72 hours aff gjene. er than "natural", or	E	Elementary/Secondary (0-12) College (1-4or 5		ior Executive		ederal Government						
e filed al Hyg othe	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Nar Fanny S	_{ne (First, Middle, Ma} chachet	iden Surname)						
Vial Vial Ments Arked arked	일	Morris Blackman				City or Town State Zin Code)						
Maryland d 2 should be file th and Mental Hy T is marked oth		19a. Informant's Name/Relationship (Type. Print)		ng Address (Street and Number or Ro 5 Commonwealth Dr								
C, N 1 and Health em 27	100	Meredith L. Elrod / Daught		osition (Name of matory or other place)		Oc. Location - City or Town, State						
U 0 0		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			2/2009 F	alls Church, Virginia						
baltimore, permit. Pages 1 ar Department of Her Important: If item any injury or othe	တ်	21. Signature of Funeral Service Licensee	National 2	2. Name and Address of Facility Jo								
any any	ä	Willway R. Succe	1 - 5	130 Wisconsin Ave	. NW Wash	ington, DC 20016						
-		23a. Part 1. Enter the dise se, or complications that curse shock, or heart fallure. List only one cause on each lire	the death. Do not en	iter the mode of dying, such as cardia	c or respiratory arres	st, Approximate Interval Between Onset and Death						
Physicia	n	(1) - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -										
/Medica	-	· ·	a consequence of):	Warranian Diagona								
Lamine		Sequentially list conditions, if any leading to immediate b. Arterio	a consequence of):	Vascular Disease								
uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
exection and and rial-tra		that initiated events c										
68760, Cificate be executed g physician and as the burial-transit	edical	d										
c 68 ertifica ling pl			of pregnancy			23d. Date of delivery						
Ords, P.O. Box 68 requires that the death certific pen signed by the attending phould be detached for use as should be dearly be detached for use as should be detached for use as should	Physician/M	23c. If yes, outcome 23b. Was decedent pregnant in the past 12 months? 4 Pregnant a	2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)		Month Day Year						
that the dened by the a	vsic	1 Yes 2 No 9 Unknown	a unio oi dodui									
ds, P. lires that 1 signed by d be deta	۲ ا	Part II. Other significant conditions contributing to death b	out not resulting in the	underlying cause given in Part I.		acco use contribute to the cause of death?						
rds quires en sign uld be	vd be		Prostate	Cancer	1 ☐ Ye:	s 2 ☐ No 3 ☐ Probably 4 🂢 Unknown						
Vital Records, sician: The law requires the certificate has been signe rector, page 2 should be considered.	Completed				24a. Was an autopsy	prior to completion of cause of						
The late ha	E C				perform 1 □ Yes 2							
f Vital Rysician: The its certificate his director, page	Be	25. Was case referred to medical examiner?		Other:	eath (Check only one							
> 🛪			ent 2 ER/Outpatie		Home 5 Reside	nce 6 Other (Specify)						
	į	27. Manner of Death 28a. Date of Inj 1 Anatural 5 Pending (Month, Date of Inj 2 Accident investigation				,						
Division I or Attending after death. Director: After d in by the fune	i i	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of in	jury - At home, farm, s	street, factory, office	28f. Location (Str. City or Town	reet and Number or Rural Route Number,						
Div all or A safter Direct	Certification: To	4 ☐ Homicide determined building, e	tc. (<i>Specify</i>)		VC.							
Divisit To the Hospital or Attenwithin 24 hours after deatt To the Funeral Director: completely filled in by the	, e		of my knowledge, dea of examination and/or	ath occurred at the time, date and pla investigation, in my opinion, death oc	ce, and due to the ca curred at the time, da	ause(s) and manner as stated. ate and place, and due to the cause(s)						
the H hin 24 the Fu	Medical	one) and manner s	tated.	29c. License number		Od. Date signed (Month, Day, Year)						
10		29b, Signature and title of certifier Kalent H. Luces	MD	MD D0055522		08/10/2009						
		an Name and address of person who completed range of	death (Item 23a) (Type	e. Print)								
		Robert H. Gerard MD 1500 F	orest Gler	n Rd. Silver Sprin	ng, MD 209	910						
	State	31. Date filed (Month, Day, Year) 3. Regist	trar's Signature	while.								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First. Middle, Last) 2. Date of Death 3. Time of Death Day August 8, 2009 Margaret Thompson Bartlett 5:50 P 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4 W. Melrose Street Chevy Chase Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
June 30,1983 9. Birthplace (State or Foreign 5. Social Security Number 6 Sev 7. Age (In yrs. last birthday) Days Hours Min 1 □ M 2 🖾 F Washington, DC 578-08-0278 26 Usua! Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County X□Yes 2□No Md. Montgomery Bethesda 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. Apt. 808 20815 7111 Woodmont Avenue Funeral Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married 1 □Yes 2 🗷 No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edmund Bartlett, III Mary Tolley Richards 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Edmund Bartlett, III/Father 4 W. Melrose St., Chevy Chase, Md. 20815 20b. Place of Disposition (Name of Cemetery, crematory or other place)
Metropolitan
Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State August 10, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Alexandria, Va. 4 ☐ Donation 5 ☐ Other (Specify) 2009 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service License 2222 Wisconsin Ave., NW., Washington, DC 20007 M00215 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disclase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Rhabdomyosarcoma disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☒No 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☐ No 2 X No 1 □Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XINo 1 Inpatient 2 ER/Outpatient 3 DOA

/Medical Examiner certificate be executed physician and strans Box 68760 as attending asn The law requires that the death ō P.0. the signed by t Division of Vital Records, peen

or Attending

Examiner Physician/Medical ş page 2 should Completed certificate funeral director, Be this Certification: To After t To the Hospital or Attenuers, within 24 hours after death.

To the Funeral Director: Af

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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death v

72 hours after

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Department of Heal Important: if heaven any labira

Physician

Baltimore, Maryland 21215-0036

Director

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Completed

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Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the fine of Exempter traumatic event.

28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 XNatural 5 Pending investigation 2 Accident

1 □Yes 2 □ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and the of c MO

6 ☐ Could not be

determined

3 Suicide

29a, Certifie

4 Homicide

(Check only one)

MD19255

29c. License number

29d. Date signed (Month, Day, Year)

August 10, 2009

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Angiolillo, M.D., 111 Michigan Ave., N.W., Washington, D.C. 20010

State Registrar

Medical

31. Date filed (Month, Day, Year) 3. Registrar's Signature AUG 11 2009

Division or Vital Records, P.O. Box 68760,

Hospital or Attending Physician: Funeral within 2

State Registrar

Medical

ess of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add Miller

32. Registrar's Signatu

and manner stated.

31. Date filed (Month, Day, Year AUG 1 1 2009

4 Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier

🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1:58 P M 2009 Lindner Covington August Katie /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert 8826 Lafayette Drive Owings 9. Birthplace (State or Foreign Country) Virginia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12-15-1922 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours Months Yrs 86 578-22-5653 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 28a-f show 1 ☐Yes 2 📆 No Director MD Calvert Owings 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number ō "natural", or Items 23a 20736 USA 8826 Lafayette Drive Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 □Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify: Specify ģ 3 ☐ Widowed 4 ☑ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Health and Mental Hygiene. em 27 Is marked other than Elementary/Secondary (0-12) 12 College (1-4or 5+) Federal Government secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Jesse Laurence Barksdale Nina Bowen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 Is any Injury or other trauonce. 8830 Lafayette Drive, Owings, MD Frank M. Lindner, son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 08-12-09 Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, PA 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death DIABETES Immediate Cause (Final **Physician** EARS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. 9 Unknown 9 D Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by OBSTRUCTIUE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☑ No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐Yes 2 ☐ No investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

dew)

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certified

Peter

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHIEWSKI 32. Registrant Signature

ORIGINAL

1 De Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

110 HOSPITAL RD #310

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 10 AM 2.W9 SCOWNE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1241 Bast Shady Side Lane Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/21/1940 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Hours Min. 1 M 2 □ F Months Days Maryland 69 219-40-6788 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo MD Anne Arundel Shady Side 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 1241 Bast U.S.A. 'natural", or items 23a Lane 20764 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 □Yes 2 👿 No þ Yes, Give Specify Specify: white 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 heavy equipment operator construction Department of Health and Mental Hygin Important: If item 27 Is marked other any Injury or other traumatic event, If once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catterton William Webster E11a Mae ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine Catterton, wife 1241 Bast Lane, Shady Side, MD20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Lakemont Mem. Gardens 08/07/2009 Davidsonville, MD 4 Donation 5 Dother (Specify) 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter of disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or rean disease. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Month /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) l □Yes 2 □No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u></u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🐧 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificate has lirector, page 2 s 1 □Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 KW

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature

AUG 0 7 2009 Summ S. Same

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-06425 State of Maryland / Department of Health and Mental Hygiene William John Connelly, Jr. 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month August 16, 2009 1540 hrs WILLIAM JOHN CONNELLY, JR. Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's 415 71st Street Avenue Capitol Heights 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State of MAY 28, Foreign NORTH If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 28, Hours Min. MAY Months Days 228-62-8421 CountryCAROLINA Director 1X M 2 F 62 94 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County any CAPITOL HEIGHTS 1 Yes 2XXNo Prince Georges MD or 28a-f show s 23a or 28a-f shows notified at once. permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20743 united 415 71ST AVE. states 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes WHITE Specify Yes 2XX No specify: If Yes, Give Year 4 X XDivorced ρ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) ted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) I other than "r the Medical E PRIVATE Comple ARCHITECT 21215-0036 12TH ant of Health and Mental Hygiene.

other traumatic event, the Med 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) SARA T. THORNE CONNELLY WILLIAM JOHN CONNELLY, SR. Be (Street and Number or Rural Route Number, City or Town, State, Zip Code) _{19a. Informant's Name/Relationship (Type, Print)} Sara K. Buettner-Connelly 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 29 2000, 1819 Biltmore ST. NW #A, WASH., DC 20009 DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, Augüst natory of other place) ERDALE PARK CREMATORY Burial 2 X X remation 3 Removal from State RIVERDALE, MD 19, 2009 Donation 5 Other Specify TERRENCE L. JOHNSON FUNERAL SERVICE, PA 21. Signature of Funeral Service Licensee TEARENCE L. JOHNSON 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart

Approximate Interven Physician Between Onset and failure. List only one cause on each line /Medical Death a.Atherosclerotic cardiovascular disease Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and - transit requires that the death certificate be executed **4a, perME, g894 8/26/** 23a, 27, permE, g894 8 Physician/Medical X AMENDED X UNPENDED attending physician for use as the burial -Box 68760 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown g Unknown signed by the a be detached for 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o Yes 2 ✔ No 3 Probably 4 Unknown þ σ. Completed Division of Vital Records, 24b. Were autopsy findings available 24a. Was an the Funeral Director: After this certificate has been appletely filled in by the funeral director, page 2 should prior to completion of cause of autopsy death? performed? ✓ Yes 2 No Yes No 26 Place of Death (Check only one) Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Be Other₄ Hospital: 1 Residence 6 V Other: Scene Nursing Home 5 Inpatient 2 ER/Outpatient 3 1 V Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 1 X Natural Yes 2 Pending 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature O.C.M.E. August 17, 2009 مے 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Victor Weedn MD JD 31. Date filed (Month, AUG 19 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001 OCMF 2006

Roderick Caine

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-06369 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar

1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day August 14, 2009 0719 hrs RODERICK CAINE **Medical Examiner** c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Charles Civista Medical Center La Plata 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. 7. Age (In yrs. last birthday If Under 1 Year 5. Social Security Number 6. Sex **Funeral** Months Hours Days 1971 Director 522-04-1821 38 JUNE 5. Country) COLORADO 1 X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 1 XYes 2 No CHARLES WALDORF MARYLAND hours after death with the Maryland Director 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code UNITED STATES 6005 SIRENIA PLACE 20603 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. White, etc. Armed Forces 1 Never Married 2 X Married Yes Specify: BLACK Yes 2 X No specify f Yes. Give Year Widowed Divorced ò 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) MD 21215-0036 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than BUSINESS RETAIL MANAGER COMMUNICATIONS 4 YEARS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ATHALEA CONNER CAINE POMPAY EDGAR CAINE Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SHERI L. CAINE / WIFE 6005 SIRENIA PLACE, WALDORF, MARYLAND 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State HERITAGE MEMORIAL CEM AUGUST 22,2009 WALDORF, MARYLAND Donation 5 Other Specify: nature of Fureral S vince Licensee THORNTON FUNERAL 13439 LIVINGSTON L HOME, P.A. ROAD, INDIAN HEAD, LYDA C. THURNTON JOHNSON M00583 MARYLAND 20640 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval Between Onset and Physician failure. List only one cause on each line. /Medical Death a.Cardiomegaly Immediate Cause (Final disease **xaminer** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last **DIVISION OF VITAL RECORDS, P.O. BOX 68760,** Hospital or Attending Physician: The Jaw requires that the death certificate be executed 24 hours after death. and transii Physician/Medical AMENDED 23a, PII, 27, permE, g895 9/17/09 TT XUNPENDED attending physician for use as the burial -23d. Date of delivery 23c. If ves, outcome of pregnancy IF FEMALE 23b. Was decedent pregnant in the Year Month Day Live birth 3 Ectopic pregnancy Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed l þ Yes 2 ✔ No 3 Probably 4 Unknown Cirrhosis of liver Completed s been s should l 24b. Were autopsy findings available 24a. Was ar autopsy prior to completion of cause of death? this certificate has performed? 1 🗸 Yes 2 No ✓ Yes 2 26 Place of Death (Check only one 25. Was case referred to medical Be Other 4 Residence 6 2 V ER/Outpatient 3 DOA Nursing Home 5 Inpatient 1 V Yes After 28a. Date of Injury (Month, Day, Year 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death 1 X Natural Pending Yes 2 To the Funeral Director: completely filled in by the Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier August 15, 2009 O.C.M.E. anti 30. Name and ddress of person who completed cause of death (Item 23a)

State Registrar

Margarita Korell MD.

31. Date filed (Month,

arks

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

9 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State	e of M	aryland		artmen <i>tificat</i>				ental Hy	/giene		2	271	72
			1. Decedent's Name (First, Middle	e, Last)								2. Date of D Month	eath Day	y Yea		3. Time of De	əath
	Physici /Medio		WARREN	E. C	HRTST	OPHER	JR.					Aug.		, 2009		9:05	p^{M}
Ž	Examin		4a. Fecility Name (If not institution					4b. City,	Town, or	Location of	of Death		4c.	County of De	ath		
			1210 Market St	., Apt.	E-7			Poco	moke	City	7		Wo	orcest			
	Funeral		5. Social Security Number	6. Sex	7. Aç	ge (In yrs. las	st birthday)	If Under Months	1 Year Days	If Under	24 Hrs. Min,	8. Date of B (Month, D	irth ay, Year)	9. 6	Birthplece Country)	e (State or F	Foreign
	Director		227-24-1194	1(X M 2□	15	83	3 Yrs.					March		926		VA	
	and *		Usual Residence of Decedent 10a. State 10b. County			10c. City.	Town or Lo	cation							10d.	Inside City	Limits
	Aaryli Pho	ō	MD Worce			Dogo	rvolro	C:+								1√ Yes 2	□ No
	28a-	Director	10e. Street and Number	prer		FOCO	noke	10f. Zip	Code				10a. Citi	zen of What	Country	?	
	With Sa or	<u></u>	1210 Market St						.851				U	SA	,		
	death with the Maryland ms 23a or 28a-f ahow r.r.ust be notified at	Funeral	11. Marital Status	12. Was		Ever in U.S.	. 13. \	Was Dece	dent of His	spanic Ori	gin? (Spe	cify Yes or N		14. Race - A			
	or Ital		1 Never Married 2 Marr	ned 1 🔲	ed Forces? Yes 2√2				-		n, Puerto I	Rican, etc.)		Black, W			
200	be filed within 72 hours after death with the Marylan Hygiene. de Hygiene. de other than -natural; or frams 23s or 28s-f show avent, the Medical Examiner must be notified at	by	3√D Widowed 4 Divorced	II Ye Y <i>e</i> ar	s, Give∠\ or Dates:			1 🗌 Yes	2X.1 No	Specify:				Specify:	Black	ζ	
<u>0</u>	72 ho	Completed	15. Deceden (Specify only highe	t's Education	ited)		16a. Deced	kind of wo	rk done d	uring most	t of workir	ng	16b. Ki	nd of Busine	ss/Indust	try	
N	of thin	du.	Elementary/Secondary (0-12)		ge (1-4or	5+)	lite. L	DO NOT u	se retired))							
N	ygier ygier her ti	S	7	()			Tru	ck Dr	iver	40 44-15-	-d- N			eafood			
Ě	lid be fi	Be	17. Father's Name (First, Middle,		Can							(First, Middle	e, Maiden	Surname)			
5	ges 1 and 2 should be it of Health and Mental if item 27 is marked or or other traumatic av	To	Warren E. Chri		•	•	10h Mailie		(Street o			Brown Route Numi	har City o	. Town State	a Zin Co	dal	
Mai	d2s/ han 7 is r traur		19a. Informant's Name/Relations Essie M. Ross,					_				, VA	2339		s, 21p 00	00)	
d)	os 1 and of Health item 27		20a. Method of Disposition	TITCIN		20b. Plac	ce of Dispo	sition (Nar	ne of			ate		ocation - City	or Town,	State .	
و	ages nt of r: If it		1 Burial 2 □ Cremation		from State		netery, cien ernac				08/1	6/09	Hor	ntown,	VΑ		
Baltimor	nit. Partme artme ortan injury		'4 □Donation 5 □ Other (S		1	_ LCID	-		-	s of Facilit		.0703	TIOL	iicowii,	VII		
ă	permit. Pages 1 Department of F important: If ite any injury or ot once.		& Mana	0	PTV	30.					,	meral	Co.	Accoma	ic, V	<i>J</i> A 23	301
			23a. Part1. Enter the disease, or	complications	hat carse	d the death.	Do not ent	er the mod	e of dying	g, such as	cardiac o	r respiratory	arrest,		Ap	proximate terval Betwe	
	nysician		shock, or heart failure. List Immediate Cause (Final				011	ACC	12%	40	A	Ler :	7	1	Or	nset and De	ath
	/Medical		disease or condition resulting in death)	a. Du	e to for as	EBR s a conseque	nce of):) <u></u>		017-	//	-07,	1 6-1	4/	M	1 N/V 7	4
	Examiner				1401	PET	216	EN	Si	DN	į.				4	P.S	
	SEDVER!	ner	if any, leading to immediate Due to (or is a consequence of):										-				
	cuted nd ransi	Examin	Cause (Disease or injury that initiated events	c													
Ď,	e exe ien a urial-i		resulting in death) Last	Du	e to (or as	a conseque	nce of):										
04/8 8/00	death certificate be executed e attending physicien and id for use as the burial-transit	dlcal		d													
Õ	e as	Mec	IF FEMALE:	1				- 4									
X D D	ath c	lan	23b. Was decedent pregnant in the past 12 months?	101	ive birth	of pregnance 2 Fetal d	leath 3□	Ectopic p						23d. Date of Month	delivery Da	y Ye	ar
	the a	by Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		regnant a Jnknown	it time of dea	ith 5∟	Other (sp	өспу)								
7.	that the ed by th detache	P	Part II. Other significant condition	ons contributing	to death b	out not result	ing in the u	nderivina o	ause give	in in Part I.		23e. Did	tobacco u	use contribute	to the c	ause of dea	ath?
	w requires that the death certific been signed by the attending p should be detached for use as		, un,					,	g				Yes 2		Probably		
	requ been shoul	Completed							-			24a. Wa		Odb Word	autonou	findings av	aulahla
ě	The law ite has b	Id II										aut	opsy formed!	prior death	to compl	etion of cau	se of
		- 1						_				1 Yes	2 No	101	es 2	No	
VII A	sician: The law certificate has t irector, page 2 s	o Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 No	Hospital:	4.00	ACI 51	D/O		Othe	A.F.		Check on		C (30) /C) id)		
ō	Physical dispressional dispres	-	1 Yes 2V No 27. Manner of Death	28a. [1 ☐ Inpati Date of Inju	ury 2	R/Outpatien 8b. Time of		^^	4 🗀 140		ne 5 KRes 28d. Describe			pecity)		
5	th. Afte	to	Natural 5 ☐ Pendir 2 ☐ Accident investi	9	Month, Da	ay Year)	Injury	М	8c. Injury Work 1 ☐ Y	:? /es 2 □	No						
Division	Atter r dea ector by the	ifica	3 ☐ Suicide 6 ☐ Could	not be 28e. I	Place of In	jury - At hom tc. (Specify)	e, farm, str	eet, factory	, office		2	28f. Location			Rural R	oute Numbe	∍r.
S	after a file of in b	Certification:	4 Homicide		ouilding, e	tc. (Specity)						City or I	own, State	"			
	To the Hospital or Attending Physicien: with 24 hours after death To the Funeral Director: After this certifica completely filled in by the funeral director,			ng Physicien: T													
	ha Hi in 24 he Ft	edical	(Check only 2 Medical one)	Examiner: On and	manner st	ated.	n and/or in	estigation	, in my op	inion, dea	un occurre	ed at the time					
	To t To t Com	Σ	29b. Signature and title of certifie	(/		'\	290	. License			_ /		te signed (M		y, Year)	
			1/1 4	8-77		· Wy	P		PU	002	777	6	C	8-1	//-	07	
2	Δi		30. Name and address of person	who completed	cause of	death (Item 2	За) (Туре,	Print))		1	· ·	1		,	. /	
D	Al		31. Date filed (Month, Day, Year)	10	10	O 011)	O	7. +	000	DAG	O,	1110	316	102			
	Sta Registr	-	AUG 1 2		Just 1	rar's Signatu	4. 4	arks	/								

DHMH 17 Rev 1/2001

09-06144 Janice Crosse

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

affice Crosse		1- For State	state of Marylan	•	artment of <i>rtificate of</i>		id Merii	-	Reg. No. 200	9 27173	
Physici	an/	Registrar 1. Decedent's Name (First, Mid	ddle,Last)					2. Date of De	ath Day Year	3. Time of Death	
Medical Exami	ner	4a. Facility Name (if not institu	Janice Lor			b. City, Town, o	s Lagation o	August 6	, 2009 4c. County of Dea	1215 hrs	
		Suburban Hospital	tion, give street and numi	ber)		Bethesda	r Location o) Death	Montgomery	ui .	
Funeral		5. Social Security Number	6. Sex 7.	. Age (In yrs.	last birthday)	If Under 1 Yes			irth(MM/DD/YYYY) 9. B Fore		
Director		220-04-3497	1 M 2 X F	38	8 Yrs.	Months Day	ys Hours	Min. 08/30	/1970	washington, ountry D.C.	
any		Usual Residence of Decedent 10a. State 10b. Count	v	10c. City	, Town or Locati	on			10d. Inside City Limits		
*				, ,	,			1 Yes 2 No			
Maryland 28a-f show d at once	Director	Maryland Mo 10e. Street and Number	ntgomery			10f. Zip Code	ithersb		10g. Citizen of What Co	untry?	
ith the Maryland 23a or 28a-f sho notified at once		7900 Badenlo	ck Way, Apt. 1	.01			20879		U.:	U.S.A.	
5 72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho at Examiner must he notified at once	Funera	11. Marital Status 1 X Never Married 2	Married 12. Was Deced					in? (Specify Yes or N Puerto Rican, etc.)	o- 14. Race - Ame White, etc.	rican Indian, Black,	
Rer dez ", or i			1 Yes	2 x No	1	Yes 2 X No	o specify:		Specify:	B1ack	
tours al	d by	15. Decedent's Education (S	, , , , ,	completed)		's Usual Occupa		kind of work done	16b. Kind of Business	/Industry	
36 in 72 h han "n dicat E	Completed	Elementary/Secondary (0-1	2) College (1-4 2	or 5+)		istrative			Socie	al Services	
5-0036 iled within 72 Hygiene. 1 other than "	E S	17. Father's Name (First, Midd			AdiiIII	ISLIALIVE		s Name (First, Middle,		il services	
21215-0036 hould be filed within 7 nd Mental Hyglene. is marked other than utic event, the Medica	å		drow W. Crosse	:				Jean H. S			
MD 2. d 2 should the and Me n 27 is ma	욘	19a. Informant's Name/Relatio			M.C	,			mber, City or Town, Sta	te, Zip Code)	
Ore, MC ges I and 2 s of Health an If item 27	1	Jean H. Levin 20a. Method of Disposition	- nother		Place of Disposi	tion (Name of ce		Date	aryland 20853 20c. Location - City of	or Town, State	
imore, MD 2 Pages I and 2 shou ment of Health and N iant: If item 27 is n or other traumatic		1 X Burial 2 Cremati	/	State	crematory or oth	• •	·k	08/13/2009	O1ne	y, Maryland	
Baltimore, permit. Pages I as Department of Her Important: If ite injury or other tr	- 1	21. Signature of Fune al Se			22. N Hi i	ame and Addres	ss of Facility di Fune	eral Home, In	с.		
Physician		23a. Part I. Enter the disease,	1 / / /	ised the death	1118	300 New Ha	ampshir	e Avenue, Si	lver Spring, l	daryland 20904 Approximate Interval	
/Medical		failure. List only one cau	se on each line.				,			Between Onset and Death	
xaminer		or condition resulting in death									
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):									
_	Examine	cause. Enter Underlying Caus (Disease or injury that initiated	1 C.	one of uone o	of\.						
cecuted cecuted tand		events resulting in death) Las	d.	onsequence	ы).						
ial ial	Medical	UNPENDED	AMENDED								
68760, certificate bo nding physic se as the bur	J/Me	IF FEMALE: 23b. Was decedent pregnant in	23c. If yes, ou			al death 3	Ectonic	pregnancy	23d. Date of delive	ny Day Year	
Box 6876 The death certificate the attending physical for use as the	icia	past 12 months?	4 Pregnar	nt at time of de	ooth -	ner (Specify)		, programoy	NOTAL T	Day 10ai	
J. Box t the death c by the atten ached for us	Physician/	Part II. Other significant cond	a		resulting in the u	nderlying cause	given in Pa	rt 1 23e Did	tobacco use contribute t	o the cause of death?	
Records, P.O. Box The law requires that the death cate has been signed by the atte page 2 should be detached for t	۵	Sickle Cell Anemia			ioodiang ar are a	naony mg oddoo	91701111110	1Y	,	obably 4 🗹 Unknown	
of Vital Records, g Physician: The law requir ufter this certificate has been s meral director, page 2 should	Completed							24a. Was		autopsy findings available completion of cause of	
Ceco	d mo	_			-				ormed? death?	_	
tal Recian: The certificate ector, page	Bec	25. Was case referred to medi examiner?				26.Plac		(Check only one)			
of Vital ig Physician: ifter this certif	2	1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1 Inc		ER/Outpatient		Other ₄		Residence 6 Oth	er:	
_ = # ^{- ™} = I	Certification:	1 Natural 5 Pe	ending May 1, 20	Day Year) 09	2214 hrs		Yes 2	Pedestrian	struck by pick-up	truck	
Natural 5 Pending Investigation 2											
Divis Hospital or At 24 hours after of Funeral Direct stely filled in by	Cert	4 Homicide de	termined (Specify)	Local Stre	et			Flower Hill D	State) rive / Rt. 124, Gaithe	rsburg, MD	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only Certifying	Physician: To the best of xaminer: On the basis of	examination a							
5 Paris	Med	29b. Signature and title of cert	and manner stat	ted.			se number		29d. Date signed (N		
		la l	1	MA		0.0	.M.E.		August 8, 2009		
		30. Name and address of pers	·	•	,	Donn Circ	D-III	MD 24224			
	oto	Russell Alexander M 31. Date filed (Month, Day, Yea		dical Exar			, Baltimo	ore, MD 21201			
Si Regis	ate	AUG 10	2009 Jeneu		park						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Ρ 2009 6:07 AUG 5, CRUZ JOSEFINA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY WASHINGTON_ADVENTIST HOSPITAL TAKOMA PARK If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Days | Hours | Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1 □ M 2 💢 F Yrs. EL SALVADOR 85 MARCH 19,1924 216-37-9957 Director Usual Residence of Decedent 10d. Inside City Limits 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 7: marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar must be notified at TX☐Yes 2☐No Director HYATTSVILLE PRINCE GEORGES 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number EL SALVADOR 20783 6911 18th AVE. Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1X Yes 2 □ No Specifi 2 ÉL SALVADORIAN WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within 'Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOME HOMEMAKER 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CRUZ ELIGIA **GUEVARA** ۵ MACARIO 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 18th AVE., HYATTSVILLE, MD. 20783 permit. Pages 1 and Department of Health Important; If item 27 any Injury or other tr 6911 BORIS CRUZ/SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition N Burial 2 ☐ Cremation 3 ☐ Removal from State MT. OLIVET CEMETERY 8-11-2009 WASHINGTON, D.C. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. 21. Signature of Funeral Service Licensee 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 M00091 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician HYPOXIA /Medical Due to (or as a consequence of): Examiner CHRONIC OBSTRUCTIVE PULMONARY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☑ No ed by the a P.O. 9 Unknown 9 Unknowr 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. icate has been signed , page 2 should be det Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown OSTEOPOROSIS Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy performed? certificate has 1 ☐ Yes 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2√☐ No 1 ∑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 28b Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Hospital or Attendi 24 hours after death. Funeral Director: A filled in by the 24 hours To the 1 within 2 To the 1

> State Registrar

Medical

AUG 11

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

NASREEN



and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Morith, Day, Year)

20912

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Dav **Physician** 2:50 A. M Joseph 4, 2009 Danie1 Collins August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Hours Months Days 1 X M 2 □ F New York 103-14-7751 87 Director March 13,1922 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City Town or Location show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examirer must be routified at 1 ☐ Yes 2 X No Director Maryland | Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20876 12407 Milestone Manor Lane United States death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent Ever in U.S.

Armed Forces?
1 13Yes 2 □ No 1942If Yes, Give
Year or Dates: 1945 e filed within 72 hours after of Hygiene. at Hygiene. other than "natural", or iter 1 Never Married 2K Married Baltimore, Maryland 21215-0036 1 □Yes 21 No ò Specify Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Firefighter D.C. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ntai Pages 1 and 2 should be of Health and Menta ဂ္ Daniel Raymond Collins Grace Lord 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret B. Collins/Wife 12407 Milestone Manor Lane, Germantown, MD. 20876 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of I-Important: If ite any Injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Arlington Nat. Cem. 9/30/2009 Arlington, Virginia 22. Name and Address of Facility DeVol Funeral Home 21 Signature of Funeral Service Licensee 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Hypotension disease or condition resulting in death) Hours /Medical Due to (or as a consequence of): Examiner I. Bleed 5 Days Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit and Due to (or as a consequence of) Box 68760. attending physician for use as the buria certificate be Physician/Medical If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) ☐Yes 2☐No P.O. the 9 Unknown 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Atrial Fibrillation, Coronary Artery Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performe certificate 2 XNo 1 □ Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Patter death. After 1 K Natural 5 Pending Injury 1 □Yes 2 □No investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) á 4 Homicide filled in within 24 hours a

To the Funeral Hospital

To the DH

> State Registrar

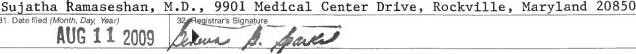
Medical

31. Date filed (Month, Day, Year) AUG 11

29a. Certifier

(Check only one)

29b. Signature and title of certifier



30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)

1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

		,	Usual Residence of Decedent					pulle 27	, 1923	D.C.	
	pug *		10a, State 10b. County		10c. City, Town	or Location				10d. Inside City Limits	
	aryla sho	7			100. Oity, 10Wi	TO LOCATION					
	Sa-f	Director	Maryland P.G.		Sil	ver Sprin	g			1 ☐ Yes 2 █No	
	+ 22 a	j.	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?	
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ther than "hatural", or items 2a or 28a-f show out, the Medical Examinar must be notified at	16	3160 Gracefie	ld Road	ad 20904			U	ISA		
	ms 2	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.		Hispanic Origin? (5	Specify Yes or No-	14. Race - Am	erican Indian	
	ter dear	Ē	1 ☐ Never Married 2 Married	If Yes specify Cuban Mexican Puerto Rica			to Rican, etc.)				
36	is at	Ş	3 ☐ Widowed 4 ☐ Divorced	1 TXYes 2 ☐ I If Yes, Give	1943-4	1 □Yes 2 X No	Specify:		_{Specify} White		
Ö	hou	찟						T.			
<u>5</u>	"naf	et	15. Decedent's Ed (Specify only highest gra	ide completed)	16a.	Give kind of work done life. DO NOT use retire	ipation during most of wo	orking	16b. Kind of Business	s/Industry	
2	withir ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+) T					7	
7	filed withir Hygiene. ther than				Tu	cernal ke	1			Sovernment	
nd	be filed within 72 ho ital Hygiene. d other than "natur event, the Micdical	Be	17. Father's Name (First, Middle, Last)					me (First, Middle, N	,		
<u> </u>		၉	Roy Leslie Co	dd			Gertr	ude Swin	ıgle		
ar	S = " =		19a. Informant's Name/Relationship (Type. Print)	19b	Mailing Address (Stree	t and Number or R	ural Route Number,	City or Town, State,	Zip Code)	
Σ	1 and 2 Health a em 27 Is		Richard E. Cob	h Jr/S	on 2	724 Sunda	nco Pl	Mulber	ru FI 3	3860	
ē,	S 1 al		20a. Method of Disposition	Dr OI./S	20b. Place of	Disposition (Name of ry, crematory or other pla	i	Date 2	Oc. Location - City of	Town. State	
و			1 ☑ Burial 2 ☐ Cremation 3 ☐					Aug. 14,	•		
ţ	t. Pg tme tant jury		4 ☐ Donation 5 ☐ Other (Specify	y)	Rock	Creek Cem		2009	Washing		
Baltimore, Maryland 21215-0036	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licer	isee	- 61-	22. Name and Addr	ess of Facility	ing Fune	ral Home	Tnc	
ш_	20 E # 9		Churchen 4	Lole Mil	00810	500 Unive	ersity]	Blvd. W.	. Silver	Spring,MD	
			23a. Part 1. Enter the disease, r c m	plications that caused	the death. Do					Approximate Interval Between	
	Dhysisian		shock, or heart failure. Lis only Immediate Cause (Final							Onset and Death	
	Physician /Medical		disease or condition resulting in death)	· viii		er with Mo	etastas:	is to Bo	ne		
A.	Examiner			Due to (or as	a consequence	of):					
		L	Sequentially list conditions.	b. Chroni							
2	p #	iner	if ally, leading to infinediate cause. Enter Underlying	Due to (or as	ā curisequerice (JI).					
)	nd rans	Examin	Sequentially list conditions, it ally, leading to ininediate cause. Enter Underlying Cause (Disease or injury that initiated events c								
o,	e exe an a rial-t		resulting in death) Last	Due to (or as	a consequence of	of):					
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Box 68760,	he law requires that the death certificate be executed e has been signed by the attending physician and tge 2 should be detached for use as the burial-transit	Physician/Medical									
×	ndin	Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy				22d Data of de	alimore.	
ă	atter for u	iar	in the past 12 months?		2 Fetal death				23d. Date of de Month	Day Year	
Ö	w requires that the de been signed by the should be detached	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	it time of death	5 ☐ Other (specify)					
σ.	d by etac	Ph									
Ś	es the	þ	Part II. Other significant conditions of	ontributing to death b	ut not resulting in	the underlying cause gi	ven in Part I.			to the cause of death?	
Records,	en s							1 □ Ye	s 2∐No 3∏F	Probably 4 Unknown	
ပ္ထ	s be	ompleted						24a. Was ar	24b. Were a	utopsy findings available	
æ	helaw ehas ge2s	Ē						autopsy	y prior to	completion of cause of	
	n: T ficat r, pa	O.						1 □ Yes 2			
₹	ding Physician; The I n. After this certificate ha funeral director, page	To Be	25. Was case referred to medical examiner?	Lii-i				ath (Check only one	9)		
<u>+</u>	this of		1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatie	ent 2 ☐ ER/Ou	tpatient 3 ☐ DOA Ot	her: 4 🗷 Nursing I	Home 5 ☐ Reside	nce 6 □Other (Sp.	ecify)	
_	ng P fter 1 nera	ᇎ	27. Manner of Death ★★Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	iry 28b. 7	Time of 28c. Injury Wo	iry at	28d. Describe ho	w injury occurred		
.0	ath. r: A	atic	2 ☐ Accident investigation		,,,,,,,]Yes 2 □No				
/is	Atte	Ę	3 Suicide 6 Could not be determined	28e. Place of Inju	ury - At home, far	rm, street, factory, office	ffice 28f. Location (Street and Number or Rural Route Numb			Rural Route Number,	
Division of Vital	To the Hospital or Attending P. within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	Certification:	4 ☐ Homicide determined	building, et	c. (Specify)	•		City or Town	, State)		
	plta ours eral fille		29a, Certifier 1 Certifying Ph	veician: To the heet	of my knowledge	, death occurred at the	time date and also	i			
	Hos Pun Fun Stely	Medical	(Check only 2 Medical Examone)	niner: On the basis o	t examination an	d/or investigation, in my	opinion, death occ	curred at the time, da	ate and place, and du	ie to the cause(s)	
	the the mple	Med	29b. Signature and title of certifier	Practit	ioner	100.11				" B V 1	
	P ≥ P 8		29b. Signature and that of centurer	aci.	comp		se number		ed. Date signed (Mon	ntn, Day, Year)	
	511		10/10	der c	1000	18	15134	2	08/10	12007	
(1	0)		30. Name and address of person who								
			Anna Sisic, CRNP			ld Road,	Silver	Spring	MD 20904	1	
	Sta		31. Date filed (Month, Day, Year)		ar's Signature			-pring,	110 20009		
	Registr		AUG 11 200	9 Centra	1 1. 1	backer					
				- /	/ (7						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . ^{Day} 2009 **Physician** August 8, 9:20 PM Choudhury Ajit /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Washington Adventist Hospital Takonia 1 a....

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | Jan. | 1, Takoma Park 5. Social Security Number 6. Sex 1 XM 2 ☐ F 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 555**-**78-4376 72 Yrs. Director India Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examination and the traumatic event, If a Medical Examination and 1 ☐ Yes 2 ☐ No Director Maryland Prince George's Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5415 75th Avenue 20706 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 □Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 🛣 No þ Asian Indian 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Professor Howard University 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jadav Chandra Choudhury Shanti Som ္ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5415 75th Avenue, Lanham, MD 20706 Valerie Choudhury, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 8/9/2009 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Road, Beltsville, MD V.13-20705 23a. Part 1. Enter the disease, or complications that caused the ath. To not inter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each lin Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Disk to (or as a nonsecuerns of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) i signed by the aid be detached for 9 Unknown 9 Unknown ۵. Part II. Otom significan contributing to de 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ઁ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has lirector, page 2 s autopsy performed? Yes 2'⊡No 2 □No 1 ☐ Yes 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 XInpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 29a. Certifier 1 🛣 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) To the within 2 To the 29b. Signatu and title of certifier 29c. License numbe 29d. Date signed (Month, Day, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar Dr. Nasreen M. Kango

31. Date filed (Month,-Day, Year)

Takoma Park,

MD

20912

7701 Carroll Avenue,

Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- State of Maryland / Departr	ment of Health and N icate of Death		giene Reg. No.? 9	27178				
I	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Dea Month	ath Day Year	3. Time of Death				
	/Media	čal	Betty Carr 4a. Facility Name (If not institution, give street and number) 4b.	. City, Town, or Location of Death	08	06 2009 4c. County of Death					
-	Examir	ıer	Bethesda Health & Rehabilitation Ctr	Bethesda		Montgomer					
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Under 1 Year If Under 24 Hrs.	8. Date of Birth		place (State or Foreign intry)				
	Director		578-50-5835 Yrs.	onths Days Hours Min.	8. Date of Birth (Month, Day 8/21/]	1914 Virg	ginia				
	and w	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locatio	on .			10d. Inside City Limits				
	Maryl fed a		MD Montgomery Bethesda				1X Yes 2 No				
	r 28e	Director		Of. Zip Code		10g. Citizen of What Cou	intry?				
	23e c		5721 Grosvenor Lane	20814		United Stat	es				
36	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural, or Items 23e or 28e-1 show metic event, the Medical Examiner must be notified at	by Funeral	Armed Forces? If Yes 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	Decedent of Hispanic Origin? (Sps. specify Cuban, Mexican, Puerto Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	Black, White Afr:					
Maryland 21215-0036	72 ho	eted	(Specify only highest grade completed) (Give kind	's Usual Occupation I of work done during most of work	ing	16b. Kind of Business/Ir					
121	filed within 72 h I Hygiene. other than "natuent, ine Vedica	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	NOT use retired)		U.S. Govern	am on t				
D	filed v Hygie other t		12 Press O		e (First, Middle,	Maiden Sumame)	ımen t				
a	2 should be f and Mental H is marked of reumetic eve	To Be	Philip Jackson	Maggie S		·					
ary	s mar	Ĭ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Ad	ddress (Street and Number or Rur		r, City or Town, State, Zi	p Code)				
	and 2 ealth n 27 i			olly Gove Road,		Spring, MD	20905				
Baltimore,	Pages 1 nent of He ant: If iter ury or oth		20a. Method of Disposition 1 □ Burial 2 ☑Cremation 3 □ Removal from State 20b. Place of Disposition cemetery, cremator	n (Name of ry or other place)	Date	20c. Location - City or T	own, State				
Ξ	t. Pag thent rtent:		`4 □Donation 5 □ Other (Specify) Chesapeake	Crematory 8/10)/2009	Beltsville,	MD				
Ba	permit. Pages 1 and 2 should b Department of Health and Mente Importent: If item 27 is marked any injury or other treumetic e <u>once</u> .		21. Signature of Funeral Service Liensee 22. Nat	ome and Address of Facility McC O Georgia Avenue	Guire Fu	neral Servi ashington.	ce, Inc. DC 20012				
	Physician		23a. Part1. Enter the dises e, or complications that caused the death. Do not enter the shock, or heart failure. Ist only one cause on each line.				Approximate Interval Between				
			Immediate Cause (Fina disease or condition) TAGE DEMENTIA								
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	The law requires that the death certificate be executed tte has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed by PI	Part II. Other significant conditions contributing to death but not resulting in the underly	lying cause given in Part I.		bacco use contribute to	the cause of death?				
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<u>ra</u>		Certification: To Be Co	25. Was case referred to medical	26 Place of Door		2 No 1 Yes	2500				
<u> </u>	Physicien: this certific al director,		examiner?	26. Place of Deat Other: 42 Rursing Ho		lence 6 Other (Speci	ify)				
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	To the within 2 To the complet	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Month,					
	7		Julaw, mo			8/7/0	-				
	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print		(01710	(
	te		Dr. Truong Bao, 9715 Medical Center Dr.	ive, #201, Rock	ville, M	ID 20850					
	Sta Registr		AUG 11 2009 Lender B. Signature	7							

09-06381 Julia Carmella Car	nce	Please Type o	or Print in Blac of Maryland / [ck Inde Departn	elible in ment of	ı k. E ı Healt	nsure th and	Ali Co Menta	pies al Hygi	Are Legi iene	ble.	F. 75 Ph	
valia carriona car	1.	For State	Of Waryland / -		cate of					Reg.	No.	200	9 2/1
Physician	/ 1	edistrar . Decedent's Name (First, Middle,Las							1	Date of Death Month D	ay Yea		Time of Death 1750 hrs
Medical Examine		JULIA CARME		<u>ELLAR</u>	ICH 14	b, City, T	Town, or L	ocation of		August 14, 2	4c. County	of Death	
1	2	4a. I acility Hame (if not mottation, give of oct and					Chestertown Queen Anne's						
Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. last b	oirthday)		er 1 Year	If Under	24Hrs. 8 Min.	B. Date of Birth		9. Birthp Foreign	New York
Director	ı	173-26-3498	M 2 X F	76	Yrs	Month	s Days	riours	IVIIII	Feb 1	5 193.	Count	try)
,		Jsual Residence of Decedent 10a, State 10b, County		Oc. City. Tov	wn or Locati	ion			. —			10	0d. Inside City Limits
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arylandar	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?									y?		
the M a or 2		1229 Fitzgera	ild St.				9148			1	U.S.A. 14. Race - American Indian, Black,		
h with	Funeral	11. Marital Status 1 Never Married 2 Marrie	12. Was Decedent E	ver in U.S.	13. Wa	s Deced (es, speci	ent of Hisp ify Cuban,	anic Origii Mexican, I	n? (Spec Puerto Ric	ify Yes or No- can, etc.)		e - America te, etc.	in Indian, Black,
r death	티		1 Yes 2 ≱	K No	1	Yes 2	X No	specify:			Specify:	Whi	te
urs afte	≱⊦	15. Decedent's Education (Specify of	or Dates:	leted) 16	Sa. Deceder	nt's Usual	Occupati	on (Give ki	ind of wor		16b. Kind of B	usiness/Inc	dustry
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within iene.	Completed	9 17. Father's Name (First, Middle, Las				18.Mother's Name (First, Middle, Maide							
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212 ould be I Ment i mark	입	19a. Informant's Name/Relationship								ral Route Numi			
MD d 2 sho lth and n 27 is		Martha Borman (daughter) 1229 Fitzgerald St. Phila., PA. 13									own, State		
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Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show. injury or other traumatic event, the Medical Examiner must be notified at ouce.	1	4 Donation 5 Other Specify: SC. 1 ECET & Taut O/21/03											
Bal permi Depar Impo	- 1	M00510 118 West Cross St Galena MD 21635											
Physician	1	23a. Part I. Inter the disease, or confailure. List only one cause on	nplications that caused t	he death. D	o not enter	the mode	of dying,	such as ca	ardiac or i	respiratory arre	st, shock, of h	neart	Approximate Interval Between Onset and
/Medical aminer	1	Immediate Cause (Final disease a Atherosclerotic Cardiovascular Disease											Death
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outed nd iransit	ш	events resulting in death) cast	d										
be exectician a	dica	UNPENDED	AMENDED								Tool Date	af daliyaa	
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be executed. After this certificate has been signed by the attending physician and luneral director, page 2 should be detached for use as the burial - transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcom	ne of pregna		etal dea	th 3	Ectopie	c pregnar	ncy	Month	of delivery	pay Year
x 68 th certi	iciai	past 12 months? 4 Pregnant at time of death 5 Other (Specify)											
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Sion Attend death. ctor;	catic	Natural 5 Pendin Accident Investig		niury - At hou	me farm st	treet fact				28f. Location (Street and Nu	ımber or Ru	ural Route Number, City
Division of Vital Records, rat or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should the fine or the funeral director.	Certification:	3 Suicide 6 Could r	not be	ijui y - At 1101	o, iaiii, si	Joi, raul	,, 0.1100			or Town,			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deached for use as the burial - transil		29a. Certifier 1 Certifying Phy	aisian. To the best of m	ıy knowledg	e, death oc	curred at	the time,	date and p	lace, and	due to the cau	se(s) and mar	ner as stat	ted.
o the lathin 2 or the lathin 2 or the lathin 2 or the lathin 2	Medical	one) 2 Medical Exami	iner:On the basis of exa and manner stated.	mination an	nd/or investi	gation, in	my opinio	on, death o	ccurred a	t the time, date	and place, al	na que to ti	onth, Day, Year)
F \$ F 8	ž	29b. Signature and title of certifier					29c. Licer	ise numbe	1		Zau. Date :	g (1VIC	and a supplied only

Chronic obstructive pulmona	ary disease			- 1			
				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No		
25. Was case referred to medical			26.Place of Death (Check	only one)			
examiner? Hos	pital: 1 Inpatient 2	ER/Outpatient 3	ng Home 5 Residence 6 🗸 Other: Scene				
1 ✓ Yes 2 No 27. Manner of Death 1 ✓ Natural 5 Pending	28a. Date of Injury (Month, Day,Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury	y occurred		
2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h	ome, farm, street, facto	pry, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State)			

30. Name and address of person who completed cause of death (Item 23a)

111 Penn Street, Baltimore, MD 21201

O.C.M.E.

August 15, 2009

Donna M. Vincenti, MD Assistant Medical Examiner 32. Registrar's Signature State 31. Date filed (Month, Day, Year)

Registrar

Please Type or Printin Black Indelibie 44k8 Frs 145 Alk Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** A^{M} Rev. Raymond J. Christ, O.S.F.S. August 2009 0320 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Hospital E1kton Ceci1 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 ☑ M 2 ☐ F Director 188-14-5735 86 FEB 23. 1923 Pennsylvania Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 10d. Inside City Limits Director 1 X Yes 2 □ No Pennsylvania Montgomery Wyndmoor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8501 Flourtown Avenue Funeral 19038 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 10. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No ģ Specify. Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chaplain/Priest Religious ages 1 and 2 should be file out of Health and Mental H t: If item 27 Is marked oth y or other traumatic eventy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Christ ပ Sophia Helrigel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Oblates of St. Francis de Sales 2200 Kentmere Parkway, Wilmington, DE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State August 10, permit. Page Department of Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Oblate Cemetery Childs, MD 2009 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line. 22. Name and Address of Facility Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cardispulmonary disease or condition resulting in death) /Medical Due to (or as a convequence of) Examiner Multioryan Fa Sequentially list conditions Examiner if any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed UTI with Sepsis and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 No 3☐ Probably 4☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed Yes 2 No 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after deat Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

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State Registrar 31. Date filed (Month, Day, Year)

Street

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bow

32. Registrar's Signature

D69048

Elkton, MD 21921

5/09

09-06455 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Guy Leroy Crumbacker 1- For State Certificate of Death Registrar 2. Date of Death Time of Death . Decedent's Name (First, Middle,Last) Physician/ August 18, 2009 0953 hrs **Medical Examiner** Guy Leroy CRUMBACKER c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Washington Hagerstown Washington County Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours Director Aug. 18 1927 Country) Maryland 1 X M 2 F 82 Yrs 219-20-0089 Usual Residence of Decedent 10d. Inside City Limits any 10c. City, Town or Location 1 Yes 2 X No or items 23a or 28a-f show Washington Hagerstown Maryland notified at once, hours after death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21740 USA Lot 147 11210 Lakeside Drive Funeral 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces' 1 Never Married 2 X Married 1 X Yes 1 Yes 2 X No specify: White If Yes, Give Year WW TT Specify Widowed Divorced the Medical Examiner ፩ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Commissary Store Clerk 8 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) event, æ Irma G. James William C. Crumbacker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21740 11210 Lakeside Drive, Lot 147, Hagerstown, MD. Mildred Crumbacker - Wife 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State or other 8/21/09 Hagerstown, Maryland Rest Haven Cemetery 4 Donation 5 Other Specify: 22. Name and Address of Facility Signature of Funeral Service License Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death Hypertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): ne cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last The law requires that the death certificate be executed 23a,27,perME, g894 8/27/09 TT Physician/Medica X UNPENDED AMENDED attending physician or use as the burial Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months? 2 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown tþe certificate has been signed by the ector, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a, Was an prior to completion of cause of autopsy performed' 1 🗸 Yes 2 No Yes 2 No 26 Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 🗸 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other DOA this 1 Yes No After 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred 27. Manner of Death Certification: 1 X Natural 1 Yes 2 No 5 Pending Director: d in by the f after death. 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) determined Homicide

the Hospital or Attending Physician: within 24 hours a

To the Funeral I

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Ling Li, MD

29a. Certifier 1 (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

w 30. Name and address of person who completed cause of death (Item 23a)

> Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

OCME

31. Date filed (Mont), Dec 32. Registrar's Signature G 2 5 leave

August 19, 2009

State of Maryland / Department of Health and Mental Hygiene 🤈 🖺 🖺 🔾 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) August 9, 2009 ear **Physician** 1440 Sophie Elizabeth Dyson /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Frederick Calvert Calvert Memorial Hospital 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. |
| Months | Days | Hours | Min. | Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** 85 579-20-8695 Jan 5, 1924 Pennsylvania Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 XNo Calvert MD Lusby "natural", or items 23a or 28a-f sh idical Examiner must be notified Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20657 11435 Stirrup Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 ☑ No Specify: 3altimore, Maryland 21215-0036 Specify: Completed by 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) US Park Police Elementary/Secondary (0-12) and Mental Hygiene. College (1-4or 5+) Federal Government Clerical - Records 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charity Edna Ruth Godley Elbert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If Item 27 is any injury or other trau 11435 Stirrup Lane Lusby, MD Beth Ann Hamm (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Aug 15 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Dunkirk, MD 4 Donation 5 Dother (Specify) Southern Mem. Grdns. 2009 21. Signature of ral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, PA J. 8125 Southern Maryland Blvd. Owings, MD Gary Coff 23a. Parti Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** LUN YEST, VE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 51205.5 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-tran and Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria pe Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy pertorme 2□ No 2 No 1 ☐ Yes or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1. Inpatient 1 ☐ Yes 2 → No 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Matural s after dea... ral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours af

To the Funeral D

completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 08-10-2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAILTIN M.D. 32. Registrar's Signature 31. Date filed (Month, Day, State AUG 12 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 9:38 ам 07 August 2009 Joanne Elliott Dobbs /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Casey House Rockville Montgomery Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 □ M 2 🗷 F 57 Director 220-58-4420 May 24, 1952 New York Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a, State 10c. City, Town or Location traumatic event. The Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Potomac Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20854 U.S.A. 10401 Great Arbor Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 No If Yes, Give 1 ☐ Never Married 2 🗷 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify þ Specify: 3 Widowed 4 Divorced Year or Dates White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eugene Elliott Rona Cobin 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health au
Important: If item 27 is
any Injury or other trau 10401 Great Arbor Drive, Potomac, Maryland 20854 Steven Phillip Dobbs - Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town. State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Judean Memorial Gardens 08/09/2009 Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licenses 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the diserse, or amplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Disono one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) **Breast Cancer** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) 68760 Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year ☐Yes 2 No Ö 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed' 1 ☐ Yes 2 X No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Nother} \) Other (Specify) \(\text{Hospice} \) 1PU 1 ☐ Yes 2 🗷 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital within 24 hours a To the Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number MD D63748 Kouat August 7, 2009 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jocelyne Toukep Kouatchou, M.D., 6001 Muncaster Mill Road, Rockville, Maryland 20855

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State Registrar 31. Date filed (Month, Day,

Registrar's Signat

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	Physicia	an l	1. Decedent's Name (First, Middle, Last)			Date of Death Month	Day Year	3. Time of Death					
	/Medic		Bertina Louise Davis	4b. City, Town, or Loc	nation of Doath	August	4c. County of Deatl	7:45a ^M					
	Examin	er	4a. Facility Name (If not institution, give street and number)	Silver S			mery						
	Funeral		Holy Cross Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birth	hday) If Under 1 Year If t	Under 24 Hrs.	8. Date of Birth		hplace (State or Foreign untry)					
	Director		336-28-1732 1□M 2√F 75 Y	rs. Months Days H	lours Min.	Feb.11		Illinois					
	D >		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location				10d. Inside City Limits					
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	the N	rect	MD Montgomery Rocky 10e. Street and Number	711e 10f. Zip Code		10	0g. Citizen of What Co	untry?					
	3a or	Ö	14431 Brad Drive	20853			USA						
30	be filed within 72 hours after death with the Maryland Hygiene. do other than "natural", or items 23a or 28a-f show event, the Marilest Evanimen instituted at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Never Married 2 Married If Yes. Give	13. Was Decedent of Hispa If Yes, specify Cuban, M 1 □ Yes 2 🎖 No Si	anic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.					
3-003p	72 hours 'natural' dical Ev	Completed b	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a.	Decedent's Usual Occupation (Give kind of work done durin life. DO NOT use retired)	n ng most of worki		l 16b. Kind of Business/	Industry					
7	within jene.	ם	Elementary/Secondary (0-12) College (1-4or 5+)			I	Data Pro	cessing					
ч	filled v Hygid Sther ent, II	ပိ	1 2 Ma	anager 18.	. Mother's Name		Maiden Surname)	CCSCIII					
	ld be lental ked c ic eve	To Be	John Becherer	l I	Bertha	Schaef	er						
ary	2 should be and Menta is marked raumatic ev		19a. Informant's Name/Relationship (Type. Print) 19b.	Mailing Address (Street and	Number or Rura	al Route Number	City or Town, State, 2	Zip Code)					
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aitimore	permit. Pages 1 and 2 should be Department of Heath and Menta Important: If item 27 is marked any injury or other traumatic ev once.		1 StBurial 2 I ICremation 3 I IBemoval from State 1	Disposition (Name of y, crematory or other place) of Heaven	Aug	11	Silver sp						
Balt	permit. Departm Importa any inju		21. Signature of Funeral Service Licenses	22. Name and Address of Francis J.	of Facility Colli	ns Fune	eral Home Silver						
	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cluse on each line. Immediate Cause (Final disease or condition resulting in death) a Adult Respiratory Distress Syndronic Due to (or as a consequence of):										
1	/Medical Examiner		Interstitial 1		-5411/11-20-0-11-11-1	WHAT IS SAID.		1 month					
5	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					yrs.					
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09/89	ificate be executed g physician and is the burial-transit	edical	Left Cerebrova	ascular Acc.	<u> </u>			2 WAD					
. Box	death cert le attending ed for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of de Month	livery Day Year					
7.	w requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in		in Part I.	23e. Did to	bacco use contribute t	o the cause of death?					
g	quires en sig utd be	ed by	Atrial Fibrillation , Colo	on Cancer,		1 □ Ye	es 20€No 3□P	robably 4 Unknown					
Vital Records,	m 03 O1	Completed	Heparin-Induced Thrombocytop			24a. Was a autops perfori	sy prior to med? death?	utopsy findings available completion of cause of					
æ			Thrombolic event in brain & 25. Was case referred to medical	Right Arm	6 Place of Deat	1 □Yes_ h (Check only on	2 M/No 1 LIYe	s 2 🖾 No					
>	lysicia is cer direct	To Be	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Ou				ence 6 Other (Spe	ecify)					
on ot	g Ph er th	tion: T		Fime of 28c. Injury at Work?			ow injury occurred						
Division	To the Hospital or Attendin vithin 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office		28f. Location (S City or Tow	treet and Number or Fi n, State)	lural Route Number,					
	To the Hospital or within 24 hours after To the Funeral Directory filled in b	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and manner stated.	e, death occurred at the time, ad/or investigation, in my opini	, date and place nion, death occur	, and due to the or rred at the time, o	cause(s) and manner a date and place, and du	as stated. e to the cause(s)					
	To the within To the Complete	Me	29b. Signature and title of certifier	29c. License nu	umber	- 2	29d. Date signed (Mon	th, Day, Year)					
	10		Barb Supanich, RSM. MD	D 000	65485		08/06	12009					
			30. Name and address of person who completed cause of death (Item 23a)				,	/					
			Barbara Supanich, MD 1500 31. Date filed (Month, Day, Year) 32 Registrar's Signature	Forest Glen	Rd.,S	ilver	Spring, N	1D 20910					
	Sta Registi		ALIG 10 2009	backet									

09-06174 Shane Taylor Davis Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 27185

1- For State Certificate of Death Reg. No.								4 0 1		1 1			
Physicia	ian/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Yea							Time of Death					
ledical Exami		Shane Taylor Da	vis						August 7,	2009		1209 hrs	
		4a. Facility Name (if not institution,	give street and nur	nber)	4	lb. City, Town,		of Death		4c. County			
		5116 Wehawken Drive				Bethesda				Montgo			
Funeral	П			7. Age (In yrs. las	st birthday)	If Under 1 Y			4	rth (MM/DD/YYY	y) 9. Birthp Foreign	Marylar	nd
Director		216-33-4454	1 X M 2 F	18	Yrs		ays Hours	IVIIII.	July	22, 199	Count	Marylar (ry)	14
	H	Usual Residence of Decedent											11 -
any		10a. State 10b. County		10c. City, 7	Town or Locati	on						0d. Inside City L	
nd show	٦	Maryland Montg	gomery	Bet	hesda							Yes 2 X	. NO
Aaryland 28a-f show 1 at once.	퓛	10e. Street and Number				10f. Zip Cod				10g. Citizen of W			1
the M	Director	5116 Wehawken I	rive			2081	6			United	Stat	es	
with as 23.	eral	11. Marital Status		edent Ever in U.S	3. 13. Wa	s Decedent of	Hispanic Orig	gin? (Spe	cify Yes or N		e - America te, etc.	n Indian, Black,	
leath r iten	Fune	1 X Never Married 2 Mar	ried Armed Fo	2 X No	li Y	es, specify Cu	pan, Mexican	, Puerto F	(icari, etc./		Cons	acian	1
iffer of II", of	3 Wildowed 4 Divolced or Dates:												
ours a	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)								lusiness/Ind	lustry			
6 72 h 111 "11	9 For the state of												
Student Education of the state								<u> </u>					
Hygin doth		17. Father's Name (First, Middle, I					1				0)		
The least of the latter of the							treet and Nur	y Ann	n Kerna	mber. City or To	wn, State, 2	Zip Code)	\neg
MD 2 d 2 shoul lth and N n 27 is m	٩				1								
, M and 2 ealth em 2		Zua, Metriod di Disposition								20c. Location	- City or T	own, State	
Ore		1 Burial 2 X Cremation 3 Removal from State Atlantic Crematory 08/09/2009 Glen B									Burnie	. Maryla	and
ti Pag tment rtant:	Maryland Montgomery Bethesda 10f. Zip Code 10g. Clitizen of What 10g. Clitizen 10g. Clitizen of What 10g. Clitizen										\dashv		
Balt permit. Departs Import		21. Signature of Funefal Service	Mu	M009	156 L"T	hibade	au Mor	tuar	y Serv	ice, P.A	1.	MD 2091	
	_	23a. Part I. Enter the disease, or o	complications that c			he mode of dy	ing, such as	ue . cardiac or	respiratory a	lver Spr rrest, shock, or h	eart	Approximate In	nterval
Physician /Medical	3 (2	failure. List only one cause of	on each line.								- 0	Between Onse Death	at and
⁻xaminer		Immediate Cause (Final disease or condition resulting in death)	a. Stab Wour	consequence of									
		O	b.	,	,								
	je.	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence of):								
Λ	Examin	cause. Enter Underlying Cause (Disease or injury that initiated	C. Due to (or as a	consequence of	7.		_						-
G as _ isi	Exa	events resulting in death) Last	d Due to (or as a	consequence of	,								
ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed r death. yether this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - transit	ledical	UNPENDED	AMENDED									-	
so, te be ysicia buria	ledi	IF FEMALE:		outcome of pregr	nancy					23d. Date	of delivery		
68760, zertificate bu iding physic	IN/M	23b. Was decedent pregnant in the				etal death	3 Ectop	ic pregna	ncy	Month	Da	ay Yea	ar
Box 687 Re death certifit The attending in the action of	Physician	past 12 months?		nant at time of de	ath 5 0	ther (Specify)							
Box e death c the atten	hys		nown 9 Unkn				and the same in S) mart 1	23e Did	tobacco use co	ntribute to t	ne cause of deal	th?
hat the ed by	by P	Part II. Other significant conditi	ons contributing t	o death but not re	esulting in the	ungeriying ca	ise given in F	art t.		es 2 ✓ No			
rds, P.O. v requires that the s been signed by the	l be								24a. Wa			opsy findings av	Telline all
ords, w requir	Completed								aut	opsy		empletion of cau	
Recol The law icate has	Ē									formed?	1 Yes	2	No
III. T	Description of Death (Check only one) 26.Place of Death (Check only one) 27. Was case referred to medical examiner? 28. Was case referred to medical examiner?												
Vital hysician: this certif	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatier	nt 3 DOA	Other ₄	Nursir	g Home 5	Residence 6	Other:	Scene	
n of Vital Records, ding Physician: The law require. After this certificate has been si funeral director, page 2 should i	⊢	27. Manner of Death	28a. Date	e of Injury	28b. Time of	Injury 28c	Injury at Wo	rk?	28d. Describ	e how injury occ abbed himse	urred elf		
On tendir eath. or: ∧	₽	The state of Death Subject stabbed himself 1 Natural 5 Pending Investigation Investigation 2 Accident Investigation Product Subject stabbed himself 1 Yes 2 No Subject stabbed himself 1 Yes 2 No											
Division tal or Attendirs after death.	<u>[</u>			ce of Injury - At he	ome, farm, str	eet, factory, of	ice building,	etc.	28f. Location or Town	(Street and Nur State)	mber or Rur	al Route Numbe	er, City
Divisi pital or Att ours after de	Certification:			Residence				- 1	5116 Weha	wken Drive, B	ethesda, I	MD	
Division To the Hospital or Attendi within 24 hours after death. To the Finneral Director: A		29a. Certifier (Check only 1 Certifying Pt	nysician: To the be	st of my knowled	ge, death occi	urred at the tin	e, date and p	olace, and	due to the ca	ause(s) and man	ner as state	ed.	
To the Hos within 24 h To the Fur completely	edical	one) 2 Medical Exam	and manner	of examination a stated.	nd/or investig				at the time, da				
F > F 8	ž	29b. Signature and title of certifie					cense numbe	er				nth, Day, Year)	
5		his ho	, mo	>			.C.M.E.			August 8	3, 2009		
		30. Name and address of person	who completed cau	use of death (Item	1 23a)								-
	Î		nt Medical Exa	ıminer 111	Penn Stre	et, Baltimo	ore, MD 21	1201					
	tate		000 2. F	tegistrar's Signati	ure And	15							
Regis	strar	AUG 11 2	009 Sens	un p.	14 mar								

Division of Vital Records, P.O. Box 68760,

Physician

/Medical 4a. Facility Name (If not institution, give street and number) Examiner niversity 5. Social Security Number **Funeral** 115-40-6994 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 23a or 28a-f show event, the Medical Examiner nust be notified at Director Maryland 10e. Street and Number 7550 Middleburg Road Funeral Items 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ő <u>ک</u> 3 Widowed 4 Divorced 'natural" Completed Elementary/Secondary (0-12) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Monce. 17. Father's Name (First, Middle, Last) Be Walker Dunlap မ 19a. Informant's Name/Relationship (Type. Print) RoseMarie Dunlap - wife 20a. Method of Disposition 1 ☐ Burial 72 🗷 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signar re of Funeral Service Licensee darou 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed burial-tran resulting in death) Last physician Physician/Medical the attending pl IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ed by the detached f g ☐ Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ cate has been si page 2 should b Completed certificate Hospital or Attending Physiclan: 24 hours after death. Funeral Director: After this certifice director, 25. Was case referred to medical Be 1 Yes 2 No Certification: To funeral 27. Manner of Death 1 Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Dieglmann, MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8+1 St dd 31. Date filed (Month, Day, Year, State 32. Registrar's Signature Registrar

Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: To the within 2

> State Registrar

DHMH 17 Rev 1/2001

'n

29a. Certifier

(Check only one)

29b. Signature and title of ce tilier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patrick Shanahan, M.D.

um

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

120 Speer Rd.

29c. License number

DBGG54

29d. Date signed (Month, Day, Year)

Chestertown, MD.

P.O. Records, of Vital this After Division death. To the Hospital within 24 hours a To the Funeral C

1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Montgomery Takoma Park 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 🛛 F 578-66-7069 66 5, Director August 1943 Argentina Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a, State 10h Counts 10c. City, Town or Location 28a-f show traumatic event, the Medical Evan, in mr. unst be notified at 1 X Yes 2 ☐ No Director Hyattsville Prince George's Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 2215 Charleston Place 20783 Items 23a Argentina Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Narried Baltimore, Maryland 21215-0036 0 1 ☐ Yes 2 X No Specify. Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Argentine Air al Hygiene. College (1-4or 5+) Attaches Office Treasurer Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be if Health and Mental Luis Zanata Adorna Furiasse ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Juan Carlos Echague / Husband 2215 Charleston Place, Hyattsville, MD 20783 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Department of F Important: If Itel any Injury or ott 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Metropolitan Crematory 8/10/2009 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death -une Immediate Cause (Final cancer **Physician** disease or condition resulting in death) /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 2 2 🗆 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 🗆 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi ces of person who completed cause of death (Item 23a) (Type, Pi 7600 Carroll Avenue ACHTCHININ 20912 Takoma Park, MDState Registrar

			for State Registrar	State of Ma	-	epartme C <i>ertifica</i>			i Mentai F	iygien Reg. N	000	9 2	7189
	Physici	an	1. Decedent's Name (First, Middle, La	ast)					2. Date of Month		av Y		ime of Death
	/Medic		MABLE C.	EALEY					Aug.		1 20		:30 a M
	Examir	ner	4a. Facility Name (If not institution, gi					r Location of Dea	ath		lc. County of		
	Funeval	_	5. Social Security Number 6.		e (In yrs. last birth		mple er 1 Year	Hills	s. 8 Date of			Georg	
	Funeral Director		,	1 DM ODE	, ,	Months		Hours Min		Day, Yea	1926	Country) NC	State or Foreign
	faryland show	'n	10a. State 10b. County		10c. City, Town								side City Limits
	28a-i	rect	MD Prince G	eorges	Temple		ip Code			10g (Citizen of Wha		
	3a or	0	6107 Harley Lan	e			20748	3		, .og. c	USA		
99	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Medical Ever item, ust be reallisd at once.	/ Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 🔯 If Yes, Give		13. Was Dec		lispanic Origin? an, Mexican, Pue Specify:	(Specify Yes or erto Rican, etc.)	No-	Black, 1	American Ind White, etc.	lian,
00	ural",	d b	3 X Widowed 4 ☐ Divorced	Year or Dates:							I	Black	
21215-0036	filed within 72 I Hygiene. kther than "nat ant, It in refici	Completed by	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 10th	ducation ade completed) College (1-4or 5	(+)	Decedent's Us Give kind of w life. DO NOT SOCIAT	ork done use retire	oation during most of w d)	orking	1	Kind of Busir	ess/Industry	hron
d 2	filed Hygi other ent, I	Be Co	17. Father's Name (First, Middle, Las	t)	LO	SUCTAL		18. Mother's N	ame (First, Mid	_		а дос	пгор
Maryland	2 should be fi h and Mental H 7 Is marked ot raumatic ever	To B	John Taylor					Joanna	Ponce	De L	eon Ta	y1or	
lar)	2 sho and I Is ma	1 3	19a. Informant's Name/Relationship	. ,,		•		and Number or				ate, Zip Code)
	1 and 2 Health tem 27 I		Juan Richards -	Son		514 Ch			Bowie,				
Baltimore,	Pages 1 ment of h ant: If ite ury or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		20b. Place of E cemetery, MD Nati			ery 8-2	Date 1-2009		ure1,	ty or Town, St $\mathrm{Md}.$	tate
Ball	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Lice	nsee N. Watts				ss of Facility Funera Land Rd.			arylan MD. 2		
- Proposition	Physician /Medical		23a. Part 1. Inter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each lir Pancrea	tic Canc	er	ode of dyir	ng, such as card	iac or respirator	y arrest,		Inten Onse	oximate val Between et and Death onths
7	Examiner		•	Due to (or as	a consequence of):							
	uted 1 .nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (ursease or injury that initiated events	Due to (or as	a consequence of):							
68760,	tificate be executed g physician and as the burial-transit	ledical Exa	resulting in death) Last	Due to (or as	a consequence of):							
O. Box 68	The law requires that the death certific atte has been signed by the attending page 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown				□ Ectopic pregnancy □ Other (specify)				23d. Date of		Year
ds, P.	uires that signed b Id be deta	è	Part II. Other significant conditions	contributing to death be	ut not resulting in t	he underlying	cause giv	ren in Part I.				ute to the cau	se of death?
Records,	The law required the law required to the law been spage 2 should	Completed							p	utopsy erform <u>ed</u> ?	prid dea	or to completion	ndings available on of cause of
of Vital	lan: Th rtificate tor, pag	0	25. Was case referred to medical					26, Place of D	1 □ Ye eath (Check on		No 1]Yes 2□N	10
f V	nystc nis ce direc	To B	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 ☐ Inpatie	ent 2 ER/Outp	oatient 3 ☐ 0	Oth	or:	Home 5 🔀 R		6 ☐ Other	(Specify)	
ion o	tending Pt leath. tor: After th the funeral	ation:	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da		me of ury M	28c. Injui Wor 1 🗆				jury occurred		•
Division	or At ter or irect	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	ury - At home, farn c. <i>(Specify)</i>	n, street, facto	ry, office		28f. Locatio City or	n (Street Town, Sta	and Number ate)	or Rural Roul	te Number,
Λ.	To the Hospital of within 24 hours at To the Funeral D completely filled in	Medical (29a. Certifier 1 Certifying P (Check only one) 1 Medical Exa	hysician: To the best miner: On the basis o and manner sta	f examination and	death occurre or investigation	ed at the ti	me, date and pla opinion, death oc	ace, and due to courred at the tir	the cause ne, date a	e(s) and mani and place, an	ner as stated. d due to the c	ause(s)
4	Vithii To the	Ž	29b. Signature and title of certifier	119	حا	2	9c. Licens	e number		29d. [Date signed (Month, Day,	Year)
			· ans	NO		1	04171	.5			8-11-	2009	
	2		30. Name and address of person who Chitra Venkatran		eath (Item 23a) (T '300 Hano		. S1	uite 301	Greer	belt	, Md.	20770)
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature								

09-06448 Ronald D. Elliott, Jr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		- For State Certificate of Death	1		Reg.	No.	000 0710		
Physiciar	1/	Decedent's Name (First, Middle,Last)			Date of Death	Month Day Year			
ledical Examin		Ronald D. Elliott, Jr.			August 17,	2009	1856 hrs		
· · · · · · · · · · · · · · · · · · ·		4a. Facility Name (if not institution, give street and number) 4b. City, To Lusby		ation of Death		4c. County of I			
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 213–96–7590 1X M 2 F 29 Yrs.		Under 24Hrs. Hours Min.	8. Date of Birth		9. Birthplace (State or Foreign Country) Maryland		
215-0036 be filed within 72 hours after death with the Maryland and Hygiene. rked other than "natural", or items 23a or 28a-f show any ent, the Medical Examiner must be natified at one.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Calvert Lusby 10e. Street and Number 1210 Sollars Wharf Road 206. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent	57 It of Hispania Cuban, Me X No sp Occupation (king life. DO (Street an ars W) ie of cemete Cremat	Action, Puerto Ripecify: (Give kind of wor NOT use retired Mother's Name (Fynthia Not Number or Ruitharf Roadry, 1972)	ify Yes or No- can, etc.) First, Middle, Ma Vakouti ral Route Numb	I. Citizen of What United S 14. Race - White, or Specify: 16b. Kind of Busin Resider Construiden Surname) S er, City or Town, by , Mary 20c. Location - C	10d. Inside City Limits 1 Yes 2 X No Country? States American Indian, Black, etc. White ness/Industry ntial action State, Zip Code) rland 20657 City or Town, State		
Physician /Medical Examiner	miner	P. O. 23a. Part I. Enter he disease, or complications that caused the death. Do not enter the mode of failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last P. O. 23a. Part I. Enter he disease, or complications that caused the death. Do not enter the mode of failure. Chlorodiflrotomethane into Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	f dying, suc	600, Lus h as cardiac or r	sby, Mai	ryland 2	20657		
execur an and al - tra		X _{UNPENDED} d. 23a,27,28a-f,perm	E, g89	6 10/20	7/09 TT				
	sician/I	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (Special Special S		Ectopic pregnand	су	23d. Date of d Month	elivery Day Year		
ires that the disagned by the	출	Part II. Other significant conditions contributing to death but not resulting in the underlying	cause giver	n in Part I.	23e. Did tob		ute to the cause of death? Probably 4 Unknown		
cords law requ	Completed				24a. Was an autops perform	y pri ned? de	ere autopsy findings available or to completion of cause of ath? Yes 2 No		
tal Rectian: The	Be	examiner?		Death (Check or					
Physic Physic at direct property of the physic phys	인	1 Yes 2 No Trospital 1 Inpatient 2 ER/Outpatient 3 DC	OA Oth			Residence 6	1		
ion of trending Pt leath. tor: After the funeral	inhaled	freon							
Division pital or Attendi ours after death. reral Director: /	Certification:	2 Accident 3 Suicide 4 Homicide Newstigation Could not be determined Could not be determined (Specify) residence	ing, etc. 2	8f. Location (St Rd or Lusb)	reet and Number ate) MD	or Rural Route Number, City Ollars Wharf			
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	ल	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the (Check only one) 2 ✓ Medical Examiner: On the basis of examination and/or investigation, in my and manner stated.							
F × 5 8	₩ We		O.C.M.E			29d. Date signed	d (Month, Day, Year) 2009		
		30. Name and address of person who completed cause of death (Item 23a) Discoult Alexander MD Assistant Medical Examiner 111 Bonn S			21204				
			oreer, Ba	altimore, MD	21201				
Sta Registr	te ar	31. Date filed (Month Day 20 20 2009 Seneral Seneral S. Janes	,						

DHMH 17 Rev 1/2001 OCME 2006

hysici		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month August 9	oay 2009	3. Time of Deat
/Media	al l	Robert George Fuerst, Sr.	ty, Town, or Location of Death		4c. County of Death	
Examir	er	4a. Fecility Name (If not institution, give street and number) 4b. Ci Prince George's Hospital.	Cheverly	1	Prince Geo	orge's
		5 Social Security Number 6 Sex 7, Age (In yrs. last birthday) If Un-	der 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea	9. Birtho	place (State or For
uneral rector		577-12-3454 1\(\text{SM}\) 2\(\supers\) F 93 Yrs. Month	ns Days Hours Min.	March 28,	1916 Silve	r Spring, 1
š		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Li
item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Mydical Examinal recurs the rediffied at	jo	Maryland Prince George's Riverd	ale			1 🔀 Yes 2 🗆
r 28a	Funeral Director		Zip Code	10g. (Citizen of What Cou	ntry?
23a o	ai D	5512 Taylor Road	20737		USA	cen Indian
SE III	nuel		cedent of Hispanic Origin? (Sp specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	
l', or l	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: WWII	s 2 No Specify:		Specify: Wh:	ite
etura Cal E	ted	16a Decedent's I	Isual Occupation	rina	. Kind of Business/In	-
C D	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	work done during most of work T use retired)		ryland State Agriculture	e Departme
i E	Con	2 Chemis		e (First, Middle, Maid		
d oth	Be	17. Father's Name (First, Middle, Last)		McAuliff	2017 (30111/21/10)	
7 Is marked other than "r traumatic event, It a Med	2	George M. Fuerst	ress (Street and Number or Rur		ty or Town, State, Zi	p Code)
7 Is n traun			lor Road, Rive			
em 2 ther		20a. Method of Disposition 20b. Place of Disposition (competery, crematory)	Name of	Date 20c	. Location - City or T	own, Slate
t: H it		1 🖾 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) To the following state of the	10/10	/2009 Br	entwood,	Maryland
Important: If item 27 is any injury or other tra	1 9	4 Doubletton 6 Double (Appens)	e and Address of Facility	4	739 Balti	more Ave
any ir	1 8	Bankle RAN Rosers Gasch	n's Funeral Hom	ne, P.A. H	yattsvill	e, MD 20
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Betwee Onset and Dea
sician	. 0	Immediate Cause (Final disease or condition Fatal Caroliac	Arrythm	ira		Onset and Dea
ledical		resulting in death) Due to (or as a consequence of):		0001-		
aminer		Sequentially list conditions b. Carolio - Humo	nary Al	rest		
#	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	J			
ician and burial-transit	Examine	that initiated events c. resulting in death) Last Due to (or as a consequence of):				
sician e buria	calE					
phys s the	dic	d.				
attending physi	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. II yes, outcome of pregnancy 23b. Was decedent pregnant	nic pregnancy		23d. Date of deli	
a atte	Physician/Medi	in the past 12 months? 4 Pregnant at time of death 5 Othe	r (specify)		Month	Day Yea
ned by the a	hys	9 Unknown			cco use contribute to	the source of door
pendi pe de		Part II. Other significant conditions contributing to death but not resulting in the underly	ing cause given in Part I.		2 □ No 3 □ Pr	
been si	ed	Diabetic			1	
(1)	Completed by			24a. Was an autopsy performe	24b. Were au prior to death?	topsy findings ava completion of caus
his certificate her	No.				No 1 ☐ Yes	2 X No
artific octor,	Be (25. Was case referred to medical examiner?	Other	ath (Check only one)		
this or	2		DOA Other: 4 Nursing F	fome 5 Residence		cify)
n. After th funeral	on:	1 Natural 5 Pending (Month, Day Year) Injury	Work?		,,	
tor:	Icat	2 Accident investigation 3 Suicide 6 Could not be 280 Place of Injury. At home farm street is		281. Location (Stree	et and Number or Ri	ural Route Numbe
Direc in by	Certification;	4 Homicide determined building, etc. (Specify)		City or Town,	अत्यक्ति)	
within 24 hours after dear To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occur	urred at the time, date and place	a, and due to the caus	se(s) and manner as	s stated. e to the cause(s)
e Full	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occur 2 Medical Examiner: On the basis of my knowledge, death occur and glanner stated.	ation, in my opinion, death occi	Jired at the time, date	e and place, and con	
withii To th comp	M	29b. Signature and title of certifier	29c. License number		d. Date signed (Mont	iii, Day, Tear)
		VI- M/R	0006536	/	0/7/6	7
. /						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Day Year 2009 4c. County of Death NICOMICO Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Voar 10d. Inside City Limits 1 ☐ Yes 2 No 10g. Citizen of What Country? 14. Bace - American Indian Black, White, etc lack 16b. Kind of Business/Industry Garment 18. Mother's Name (First, Middle, Maiden Surname) Jane 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD. 21659 Rhodesdale 20c. Location - City or Town, State Petersburg, MD. Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? 1 □Yes 2 | HO 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) HOO5936 8/8/6 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E. Carroll MD 21801 32. Regi rar's Signature

3. Time of Deaff

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, page 2 should After this

Be

Certification: To

Medical

25. Was case referred to medical

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident 3 ☐ Suicide

4 Homicide

(Check only one)

31. Date filed (Month, D.

29b. Signature and little of certifier

115/0/1

29a. Certifier

Hospital:

100

5 ☐ Pending investigation

6 ☐ Could not be

determined

State Registrar

within 24 hours area control to the Funeral Director; Aff

			For 1 _ State		State of Ma	aryland		artment of H r <i>tificate of L</i>		d Mental Hy	-	1000	07100
			Registrar 1. Decedent's Name	(First, Middle, La	st)		Cei	lilicate of L		2. Date of De	Reg. No.		3. Time of Death
	Physicia /Medic		Cecile	,	Freen	nan				August	8, ^{Day}	009 Year	4:15 P ^M
	Examin		, ,		e street and number)			4b. City, Town, or		eath		County of Death	
d			Suburba 5. Social Security Nu	n Hospit		e (In yrs. las	et hirthday)	Beth If Under 1 Year	nesda If Under 24 H	Irs. 8. Date of Bi	rth	Montgome 9. Birtho	ery place (State or Foreign
	Funeral Director		034-09-40		□ M 2□XF	94	Yrs.	Months Days	Hours M	Dec . 20), Year)	14 Mas	sachusetts
	and w		Usual Residence of D	Decedent 10b. County		10c. City,	Town or Lo	cation			_	1	0d. Inside City Limits
	Maryla -f sho	tor		Montgome	rv		Kens	sington					1 □Yes 2 XNo
	h the	Directo	10e. Street and Num					10f. Zip Code			10g. Citiz	en of What Cour	ntry?
	23a c		3620 I	ittledal	e Road				0895			USA	
	er dea items	3020 Littledale Road ZU895 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. Armed Forces?) 14. Never Married 2 Married 15. Was Decedent Ever in U.S. Armed Forces? 16. Yes 2 XINo								(Specify Yes or N erto Rican, etc.)	0- 1-	 Race - Americ Black, White, 	
5-0036	filed within 72 hours after death with the Maryland Hygiene. wther than "natural", or items 23a or 28a-f show ent, Ite Medical Exmutrier must be rediffed at	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 2 No 1 Yes 2 No Specify: Year or Dates:								5	Specify: Whi	.te	
ک د	72 ho 'natur	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker								vorking	16b. Kin	d of Business/In	dustry
121	within ene.											Own Home	
מ											e, Maiden S	Surname)	
lar	should be and Mental smarked o	To E	Henry	Fr	eeman				Anna]	Doobii	ล	
Maryland	2 sho n and ls ma rauma		19a. Informant's Nar		**	- 7		ng Address (Street a					Code)
	s 1 and 2 should of Health and Mer item 27 Is marke other traumatic		Alison Fr		aughter	20b. Pla		Elm Avenu esition (Name of matory or other place		Oma Park Date		20912 cation - City or To	own, State
altimore,	Pages nent of int; If it		1 Å Burial 2 □		Removal from State			matory or other plac emorial Ga		/11/2009	Oli	ney, Mar	yland
Balti	permit. Pages Department of Important; If it any Injury or o		21. Signature of Fun	neral Service Licer	nsee	*		2. Name and Addres Onald V +400 Powde					
			23a. Part 1. Enter the	e disease, or com	plications that caused	the death.						IIIe, Pil	Approximate Interval Between
	Physician		Immediate Cause (F	Final	one cause on each lin	16. COV I	an	Arter	- D	iskes	e		Onset and Death
	/Medical Examiner		resulting in death)		Due to (or as	a conseque	ence of):	and the same of th					
		e	Sequentially list conditions if any, leading to imn	ditions, nediate	b Due to (or as	a conseque	ence of):						
3	cuted nd ransit	Examiner	Cause. Enter United Cause (Disease or in that initiated events resulting in death) La	niury	С								
ŠĆ,	ificate be executed g physician and is the burial-transit		resulting in death) La	ast .	Due to (or as	a conseque	ence of):						
09/89	ficate physical	edical			d								
XOS	death certifi ie attending id for use as	In/Me	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outcome 1 ☐ Live birth			☐ Ectopic pregnanc			2	3d. Date of deliv	•
o.	0 0	Physician/M	in the past 12 n 1 □ Yes 2 ☑ 9 □ Unknown		4 ☐ Pregnant a 9 ☐ Unknown			Other (specify)				Month	Day Year
". J.	law requires that the das been signed by the 2 should be detached	by Ph	Part II. Other signific	cant conditions	contributing to death b	ut not result	ting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco us	se contribute to t	the cause of death?
ords	equire en sig ould b									_ 10	Yes 2]No 3□ Pro	babły 4 💢 Unknown
Vital Records,	2 8 2	Completed								— 24a. Wa aut per 1 □ Yes	opsy formed?		opsy findings available ompletion of cause of
ıta	sician: The certificate h rector, page	Be C	25. Was case referre	ed to medical				T		Death (Check only			
5	Physic this c	၉	1 ☐ Yes 2 ☑ ↑		Hospital: 1 ☐ Inpatie		R/Outpatie 28b. Time o	nt 3 DOA Oth	4 LI Nursin	ig Home 5 ☐ Re			ify)
0	iding th. After funer	tion	1 Natural 2 Accident	5 ☐ Pending investigatio	(Month, Da	y, Year)	Injury	Worl	yat <br Yes 2 □ No	Zog. Describe	riow injury	occurred	
Division	I or Atter after dea Director I in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		ury - At hon c. <i>(Specify)</i>	ne, farm, st	reet, factory, office		28f. Location City or To	(Street and own, State)	d Number or Run	al Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. Ve the Funeral Director: After this certifica completely filled in by the funeral director, p.	Medical C	29a. Certifier (Check only one)	1 ☐ Certifying P 2 ☐ Medical Exa	hysician: To the best miner: On the basis o and manner st	f examination	rledge, dea on and/or in	th occurred at the timestigation, in my convestigation, in my converted at the timestigation.	me, date and popinion, death o	lace, and due to the	e cause(s) e, date and	and manner as place, and due	stated. to the cause(s)
	To the within To the Comple	Med	29b. Signature and t	title of certifier	0			29c. Licens			29d. Date	e signed (Month	, Day, Year)
	5) M	AC	Cieo	nno	1	DO	10689	6	81	8107	
					completed cause of c				n Road	Rethesd	a. MD	20814	
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	Registr	ar	AUG	3 - L ZUU	J Senter	Ja.	149 466	4					

FREEMAN, CECTL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2009 7:32 P August 05, Raymond Leonard Fairchild Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 12571 Coral Grove Place Germantown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/07/1951 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday, **Funeral** Months Days Hours Min. 1 XM 2 F **Director** New Jersey 57 144-46-4176 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits event, the Medical Exeminer hast be notified at 1 ☐ Yes 2X No Director MD Germantown 28a-f Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 23a 20874 12571 Coral Grove Place United States Funeral 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No "natural", or Items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2 🖾 No Specify: à Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Oil Company 12 Senior CAD Operator marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fii th and Mental F is marked otl Be Marie Lauer ဥ Raymond Leonard Fairchild Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s' f Health a 12571 Coral Grove Place Germantown, MD. 20874 Jane Fairchild (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If itea August 07 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Matropolitan Crematory 2009 Alexandria, Virginia 22. Name and Address of Facility Signature of Funeral Service Li DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Respiratory Failure /Medical Due to (or as a consequence of) Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): death certificate be executed Exami Acute Myelogenous Leukemia sician and burial-trans Due to (or as a consequence of) physician the burial Box 68760. Physician/Medical attending p as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month 4 Pregnant at time of death 5 Other (specify) I ☐ Yes 2 ☐ No Ö the 9 Unknown 9 Unknown 9 signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 □Yes 2 □XNo Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 Yes 2 X No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 124 hours after death.

le Funeral Director; A
bletely filled in by the fu death. 1 ☐Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical npletely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2.

To the I complet 29b. Signature nd title of 29d. Date signed (Month, Day, Year) 29c. License number 9 ins August 06, 2009 D0057305 dress of person who completed cause of death (Item 23a) (Type, Print) Jeremy Janssen M.D. 7 Granite Place #14 Gaithersburg, MD. 20878 31. Date filed (Month, Day, Year) 32 Registrar's Signature State AUG 11 Registrar

			For State Registrar	State of Maryland /	Department of I			iene eg. No.?	27195
			1. Decedent's Name (First, Middle, La	est)			Date of Death Month	n Day Year	3. Time of Death
	Physici /Medic		Amonia Jean	Gilles			August		5:05P M
	Examin		4a. Facility Name (If not institution, given	,		or Location of Death		4c. County of Deat	
week			Manor Care of 5. Social Security Number 6. S		Lai	rgo Tif Under 24 Hrs.	8. Date of Birth	Prince	Georges hplace (State or Foreign
	Funeral Director				7 Yrs. Months Days	Hours Min.	(Month, Day, July 22	Year) Co	aiti
	/land		10a. State 10b. County	10c. City, To	wn or Location				10d. Inside City Limits
	a-f sh	cto	MD PO	Ter	mple Hills				1 XYes 2 No
	be filed within 72 hours after death with the Marylan ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, it a Madical Experiment or nut it a madified at	Funeral Director	10e. Street and Number		10f. Zip Code		10	0g. Citizen of What Co	•
	ath w	ral	5000 Temple Hi	T		748		United S	
	items	in l	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 No	13. Was Decedent of I If Yes, specify Cub	an, Mexican, Puerto	ecity yes or No- Rican, etc.)	14. Race - Ame Black, White	
36	Irs aft	by F	1 ☐ Never Married 2 ☐ Married 3X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 □Yes 2 XNo	Specify:		Specify:Bla	ıck
5-0036	2 hou	ted	15. Decedent's E (Specify only highest gr	ducation 16	a. Decedent's Usual Occu	pation	ing	16b. Kind of Business/	
2121	e. an "n	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done life. DO NOT use retire		ng	· · · ·	
21	ed wii lygien her th		12		Seamst		(Fine 4 & 6 inteller &	Privat	.e
and	be fil ntal H ed oth even	Be	17. Father's Name (First, Middle, Last			18. Mother's Name			
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Exempter must be notified at	ဥ	Arthur Alphor 19a. Informant's Name/Relationship		9b. Mailing Address (Street	t and Number or Bur	al Boute Number	City or Town State	Zin Code)
Σ	id 2 s Ith an 27 is : trau			rt/granddaught	5000 T	emple Hi Hills,	ll Road	1 7 4 0	.,
<u>6</u>	t Hea f Hea item other		20a. Method of Disposition		of Disposition (Name of tery, crematory or other pla	,	Date	20c. Location - City or	Town, State
e E	Page: ient o nt: if i		1 → Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci		tage Memor.		4/09 tery	Waldorf	, Md.
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If item 27 i any injury or other tra		21. Signature of Funeral Service Lice		22. Name and Addre	ess of Facility HO	& Panh	Edwards	F.H.
m	permi Depar Impor any ir		sance?	Murud	3910 Sil	ver Hill	Řd., S	Suitland,	Md.20746
			23a. Part/1. Enter the disease, or con shock, or heart failure. List only	nplications that caused the death. Do	o not enter the mode of dy	ing, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
-	Physician		Immediate Cause (Final disease or condition	_a Failure to	Thrive				Oriset and Death
To the second	/Medical Examiner		resulting in death)	Due to (or as a consequenc					
	LXummer	-E	Sequentially list conditions,	b. Advanced Do Due to (or as a consequence					
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequenc	c 01).				
Ć,	ate be executed hysician and the burial-transit	Exal	that initiated events resulting in death) Last	C Due to (or as a consequenc	e of):				
Box 68760,	ate be hysicia he buri	cal		d					
68	rtifica ng ph as th	l edi							
30X	eath certific attending p for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea	th 3 ☐ Ectopic pregnan	су		23d. Date of de Month	livery Day Year
.E	e dea the al	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)			Working	Day
P.O.	or Attending Physiclan: The law requires that the death certificate be executed infer death. Jiffer death. Jiffer death. Jiffer this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit		Part II. Other significant conditions	contributing to death but not resulting	in the underlying cause gi	ven in Part I.	23e. Did tot	pacco use contribute to	the cause of death?
ds,	w requires t s been signe should be o	d by	Thromboembolio				1 □ Y€	s 2₽No 3□P	robably 4 Unknow
Sor	v requ beer shoul	Completed				•	24a. Was a	n 24h. Were a	utopsy findings available
Re	he lav e has ige 2	d mc	Extremities	-			autops	by prior to death?	completion of cause of
tal	i clan: Th certificate ector, pag		25. Was case referred to medical			26. Place of Deat	1 □Yes 2		2 12 No
Division of Vital Records,	ding Physiclan: The n. After this certificate h funeral director, page	To Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ER/	Outpatient 3 DOA Ot	hor:	`	ence 6 ☐Other (Spe	ecify)
0	ng Ph tter th neral	n:T	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year) 28b	. Time of 28c. Inju	ry at	28d. Describe ho	ow injury occurred	
<u> </u>	Attendii death. ctor: A y the fu	Certification:	2 ☐ Accident investigation	on	M 1 []Yes 2 □No			
Ξ	or Att fer de irect	rţţ	3 ☐ Suicide 6 ☐ Could not to determined		farm, street, factory, office		28f. Location (St City or Town	treet and Number or R n, State)	ural Route Number,
	pital o		29a. Certifier 1 Certifying P	hysician: To the best of my knowled	lan dooth occurred at the	time, data and place	and due to the c	eauco(e) and manner a	e stated
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only 2 Medical Exa	miner: On the basis of examination and manner stated.	and/or investigation, in my	opinion, death occur	red at the time, d	late and place, and du	e to the cause(s)
HA-	With To T	Σ	29b. Signature and title of certifier	101101		ise number	2	9d. Date signed (Mon	
	1					658		August	12, 2009
	(30. Name and address of person who	·		<u>Ш</u> 1Л1л	Cross	hal+ Ma	20770
	Sta	te	Rexford Babila 31. Date filed (Month, Day Year)	n M.D. /500 H 32. Registrar's Signature	anover PKW	y #IUIA,	Green	bert, Ma.	20110

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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28-Ba-5134 Market Street and Number 100 Market Street														
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Physician / Medical Examiner Physician / Medical Examiner Physician / Physician P				23a Part 1 Enter the disease or con	nnlications that caused the	death Dono								
Due to (or as a consequence of): Sequentially list conditions, list in lighted depends on injury and the past 12 months? Due to (or as a consequence of):		hteta		shock, or heart failure. List only	one cause on each line.						Interval Between Onset and Death			
Sequentially list conditions, but to consequence only: Sequentially list conditions are consequence only:	3			disease or condition	a. Due to (or as a co	need lence of	~	Carrect			4 year			
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Due to (or as a consequence of): Section Continue Continue	4	ransit	Ē	Cause (Disease or injury that initiated events	C									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Ö,	ian ar irial-t		resulting in death) Last	Due to (or as a co	nsequence of	():							
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		attend for us	ian/	23b. Was decedent pregnant	1 Live birth 2	Fetal death					•			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	5 2	the a	ysic	1 ☐ Yes 2 █No 9 ☐ Unknown		e of death	5 ☐ Other (specify)							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	, to	ied by detac		Part II. Other significant conditions	contributing to death but no	ot resulting in	the underlying cause (given in Part I.	23e. Did tob	acco use contribute to	the cause of death?			
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Vels	nis ce direc			Hospital: 1 ☐ Inpatient	2 🗀 ER/Out	patient 3 DOA	Other: 4 Nursing	Home 5 Reside	nce 6 ☐Other (Spe	cify)			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		fter the meral	ü		28a. Date of Injury (Month, Day, Ye		me of 28c. In W	jury at ork?	28d. Describe ho	w injury occurred				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		eath.	catic	2 Accident investigation										
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	losnita	t hours uneral		(Check only 2 Medical Exa										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	o4+	the f	Med		and manner stated		200 Line	nee number	20	9d Date signed (Moni	h Day Year)			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Strayt F. Selonicu, M.D. 900 Bastopte Rd. Annapolis, Md. 2140	F	Co o with Co	-	CIPAL	ilius		29C, LICE	19838		8/10/09	, 247, 1041)			
Strart F. Selonicu, M.D. 900 Bestoate Rd. Annapolis, Md. 2140				7 garage	-1400	/ltom 02-\ /	Funo Drint	11000		0110101				
	5	tw						ate Rd.	Annapa	olis, Ma	1. 21401			
State 31. Date filed (Month, Day, Year) / 32. Registrar's Signature	ľ	Sta	te	31. Date filed (Month, Day, Year)	/32. Registrar's					· · · · · · · · · · · · · · · · · · ·				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-06406 State of Maryland / Department of Health and Mental Hygiene Herman E. Greenstreet, Jr. Certificate of Death Reg. No. Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Month Day August 15, 2009 Physician/ 2250 hrs Herman E. Greenstreet, Jr. Medical Examiner c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Glen Burnie Baltimore Washington Medical Center 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number Foreign Maryland **Funeral** Min Hours Months Days 02/22/1953 56 Director 216-60-6900 1X M 2 F Yrs Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10h County any 10a State 1 Yes 2 X No Glen Burnie Anne Arundel MD 23a or 28a-f show notified at once. 10g. Citizen of What Country Directo 10f, Zip Code 10e. Street and Number USA 21061 401 Lenlow Court, Apt. B 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' Never Married 2 X Married 2 X No Yes White Specify 2 X No specify Yes f Yes. Give Year Pages 1 and 2 should be filed within 72 hours after one of Health and Mental Hygiene. Widowed 16b. Kind of Business/Industry þ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Automotive Mechanic 10 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sharlie Gray it; If item 27 is marked other traumatic event, i Herman E. Greenstreet, Sr. Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ပ 401 Lenlow Court, Apt. B Glen Burnie, MD 21061 Brenda L. Greenstreet / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore, crematory or other place) August Burial 2 X Cremation 3 Removal from State Baltimore, MD Metro Crematory, INC 2009 Donation 5 Other Spec 22 Name and Address of Facility P.A. Severna Park Funeral Home 21. Signature of Funeral Service Licensee 495 Gov. Ritchie Hwy, Severna Park, MD 21146 Approximate Interval Between Onset and Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear **Physician** List only one cause on each line. Death **(Medical** Fentanyl toxicity immediate Cause (Final dise aminer Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed AMENDED 23a,27,28a-f,perME, g896 10/6/09 TT Physician/Medical XUNPENDED attending physician or use as the burial 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Year Month Day 3 Ectopic pregnancy 23b. Was decedent pregnant in the Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 Yes 2 V No 3 Probably 4 Unknown ğ 24b. Were autopsy findings available Completed 24a Was an Records, prior to completion of cause of autopsy performed death? Yes 2 V No certificate l 26.Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: Division of Vital Be Other 4 Other: Hospital: Nursing Home 5 Residence 6 examiner? DOA Inpatient 2 FR/Outpatient 3 this 1 V Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day,Year) 28c. Injury at Work? 28b. Time of Injury After 27. Manner of Death 1 Yes 2 Xio Pending Fd 10:00 pm Fd 8/15/09 To the Funeral Director: completely filled in by the 2 Investigation 28f. Location (Street and Number or Rural Route Number, City Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State) 104 Lenlow Ct Glen Burnie, MD 6 X Could not be 3 Suicide determined (Specify) found at residence Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b Signature and title of sertific August 16, 2009 O.C.M.E. ee 30. Name and address of person who completed cause of death (Item 23a)

OCH

31. Date filed (Month, Day, Year)

AUG 20 2009

Victor Weedn MD JD

32. Registrar's Signature
ORIGINAL

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 3:10AM AUGUST 2009 NHOT MINC /Medical 4a. Facility Name (If not institution, g 4c. County of Death 4b. City, Town, or Location of Death reet and number) Examiner A12120L1 14 if Under 24 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days Hours 1 X M 2 □ F 94 OCT. 24,1914 New York Director 081-12-5355 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ▼ Yes 2 No Director Maryland Frederick Mount Airy 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 902 S. Warfield 21771 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American I Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: White Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 +Assistant Vice President Banking permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alfred Bernard Gifford Marie Victorine Desiree Verrier ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 902 S.Warfield Dr./ Mount Airy, Maryland 21771 Lydia C. Gifford / wife Saltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 08/12/2009 | Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licenses 8 E. Ridgeville Blvd./Mount Airy, MD 23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Imme fate Cause (Final **Physician** disease or condition resulting in death) /Medical consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner that the death certificate be executed burial-transi ementa that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the attending ph 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the detached Ö 9 Unknown 9 Unknown م 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Fart I. Division or Vital Records, Be Completed by sign(1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Jas autopsy page performed 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one funeral director Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury at Work? Certification: or Attending 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a)

Melvin Derclon MD 950101 (Type, Print) 6+1

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

82. Registrar's Signature

			For State Registrar	State of Maryland / Depa Cer	artment of Health and Men rtificate of Death	ntal Hygiene Reg. No.	27199
	Physici	an	Decedent's Name (First, Middle, Last) Yvonne Gilpin	Gregory		Date of Death Month Day Year 19ust 14,2009	3. Time of Death
	/Medic Examin	er	4a. Facility Name (If not institution, give st Bradford Oaks 5. Social Security Number 6. Sex	reet and number) Nursing Home 7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death Clinton If Under 1 Year If Under 24 Hrs. 8.1 Months Days Hours Min.		George inthplace (State or Foreign County) OOKlyn N.Y.
	Director		223-40-4506 1 Usuel Residence of Decedent 10a. State 10b. County	M 2XX 74 Yrs.		7/13/1935 Br	ooklyn N.Y.
	th the Maryli or 28a-f aho	Director	MD Prince	George Upper Molly Berry Rd	Marlboro 10f. Zip Code 20772	10g. Citizen of What USA	1 ☐ Yes 2€040 Country?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itams 23a or 28a-f ahow important: If Item 27 is marked other than "natural", or Itams 23a or 28a-f ahow projective of the fraumatic avent, the Marical Examinar marable notified at ONCE.	Funerai		2. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rican 1 ☐ Yes 2 🎖 No Specify:	y Yes or No- an, etc.) 14. Race - Ar Black, WI Specify: B	
21215-0036	within 72 hou iene. 'than "natura ine Madical E	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+) (Give life.	dent's Usual Occupation kind of work done during most of working DO NOT use retired) UCator	18b. Kind of Busines	ss/Industry Schools
Maryland 2	uld be filed Mental Hygi rked other itic avent,	To Be C	17. Father's Name (First, Middle, Last) Howard Harr	is	Lilli	irst, Middle, Maiden Sumame) ian Parker	
	is 1 and 2 should of Health and Men Itsm 27 is marke other traumatic	10	19a. Informani's Name/Relationship <i>(Typ</i> Alfreda Hill Wil	kerson (Daughter	ng Address (Street and Number or Fural R 30 0 MO -in-Law) Upperman	rlhoro Md 207	77
altimore,	Pages 1 ment of He tant: If Itsr jury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	Forest	Bawii cemeeqry	19/04 Richmond	
Ball	permit. Departr Imports any inji		21. Signature Funeral Service Li	450N 11	2. Name and Address of FacilityScott 5. Brookland Pk Bl ter the mode of dying, such as cardiac or re	lvd Richmond	
	Physician and physician and physician and physician and physician are transit.	i Examiner	shock, wheart sure. List only on Immediat use frind disease of ondition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	al		Interval Between Onset and Death
.O. Box 68760,	death certifi e attending id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ So 9 □ Unknown		□Ectopic pregnancy □ Other (specify)	23d. Date of Month	delivery Day Year
<u>α</u>	requires that the d een signed by the hould be detached	ρ	Part II. Other significant conditions con	tributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribut	e to the cause of death? Probably 4 Aknown
Vital Records,	The law ate has b page 2 s	Completed				24a. Was an autopsy performed? death	
of Vita	ysician: iis certific director.	To Be	25. Was case referred to medical examiner? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)	lospital: 1 Inpatient 2 EP/Outpatie	60.14	5 Residence 6 Other (S	Specify)
Division o	fing After fune	Certification:	27. Menner of Death 1 Astural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Year) 28b. Time (28b. Time) 28c. Place of Injury - At home, farm, s building, etc. (Specify)	Work? M 1 □ Yes 2 □ No	d. Describe how injury occurred f. Location (Street and Number o City or Town, State)	r Rural Route Number,
	To the Hospital or Attend within 24 hours after death within 24 hours after death To the Funeral Director: completely filled in by the	Medicai Ce	29a. Certifier 1 Certifying Physical Check only 2 Medicel Examinate		ath occurred at the time, date and place, and nestigation, in my opinion, death occurred		
)	To the within 2 To the comple	Mec	29b. Signature and title of contribut	Oine_	29c. License number D35206 a. Print) 1701 Livingian	29d. Date signed (<i>N</i>	onth, Day, Year)
			William	ompleted cause of death (Item 23a) (Type	1701 LIVINGIA 1	Root, Fr. Was	in ngto, mo
	St Regist	ate trar	31. Date filed (Month, Day, Year)	32. Registrar's Signature	parked		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Webb Malinda **Holman** 12:32AM 6,2009 ugust /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner Doctor's Community Hospital Lanham Prince Georges 8. Date of Birth (Month, Day, Year 1932 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🕱 F 76 232-52-8120 Director August 11, West Virginia Usual Residence of Decedent the Maryland 10d Inside City Limits 10a State 10h County 10c. City. Town or Location ral", or items 23a or 28a-f show 1XYes 2 □ No Director Maryland Prince Georges Landover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 20785 United States 6821 West Forest Road; Apt. 101 Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc 1 ☐ Never Married 2 X Married Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: Completed by 3 Widowed 4 Divorced "natural", Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natur any Injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Bellview Hospital, Elementary/Secondary (0-12)

12th grade College (1-4or 5+) New York City Registered Nurse s 1 and 2 should be filed wir f Health and Mental Hygien tem 27 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Webb Calloway Joe Mary ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20785 April Lynn Woodfork(Grand daughter) 3207 - 75th Avenue; Apt. 201; Hyattsville, Maryland Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Pages 1 Aug.17,2009 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Restlawn Cemetery Princeton, Virginia Signature of Funeral Service 22. Name and Address of Facility R. N. Horton Company Morticians, Tnc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on e.ch Approximate Interval Between Onset and Death ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** hns disease or condition resulting in death) /Medical a consequence of): Due to (or as Examiner has Sequentially list conditions Examiner it any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physiclan and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performe certificate 2000 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident in 24 hours are:

The Funeral Director: After the funeral filled in by 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar

31. Date filed (Month, Day, 32. Registrar's Signature AUG 11

29b. Signature and title of certifier

30. Name and address of person who

Richam Treldalor m

within 2.

mpleted cause of death (Item 23a) (Type, Print)

9500

29c. License number

13726

Mangal, Rel

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year .45 PM 2009 Miriam Hardes 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Annapolis Anne Arundel Anne Arundel Medical Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Days Year) Hours Min Months Yrs. 04-28-1918 Maryland 91 217-38-3583 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 🙀 No Lothian Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20711 6033 Fishers Station Road Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify. 3 Widowed 4 Divorced white 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) bookkeeper banking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elbert Hardestv Hamilton Tucker Elsie Mae 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6033 Fishers Station Road, Lothian, MD 20711 George J. Hardesty, spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Calvary Cemetery 08-14-2009 Lothian, MD 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736 055 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ca41 disease or condition resulting in death) Due to (or as a consequence of) len Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsv

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

Completed by

Be

2

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

altimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Experiment must be retified at once.

ector: After this certilicate has been signed by the attending physical by the funeral director, page 2 should be detached for use as the bur

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Hospital or Attending Physician: The law requires that the death certificate be executed

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Were autopsy findings available prior to completion of cause of death? perform 1 ☐ Yes 2 ☐ No 2 No 1 □Yes 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manger of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only onel and manner stated. 29d Date signed (Month, Day, Year) 29b. Signature and title of certifie

Division of Vital Records, P.O. Box 68760,

10

State Registrar

IN 31. Date filed (Month, Day, 32. Registraris Signature Year)

30. Name and address of person

who completed cause of death (Item 23a) (Type, Print)

ENSE HEHWAY

		1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment rtificate			and M	Reg	ene ()	09	27202
Physici	. n	1. Decedent's Name (First, Middle, Las.							Date of Death Month	Day	Year	3. Time of Death
/Medic		Andasia Hubbard							August	rust 8 2009 8:30 1		
Examin	er	4a. Facility Name (If not institution, give			4b. City, To			of Death			rches	
		Chesapeake Woods 5. Social Security Number 6. Se		e (In yrs. last birthday,	If Under 1	brio Year	If Under	24 Hrs.	8. Date of Birth			place (State or Foreign intry)
Funeral Director			Дм 2√Д F	76 Yrs.	Months	Days	Hours	Min.	May 7, 1	933	Mar	yland
1		Usual Residence of Decedent										
Maryland farow	_	10a. State 10b. County	t	10c. City, Town or L								10d. Inside City Limits 1 X Yes 2 □ No
	Director	MD Dorches	ter				ridge		10	g. Citizen of	What Co.	
the Marylar sath with the Marylar 239 or 289-1 show ust be notified at	ă	10e. Street and Number 525 Glenburn Ave	ກນອ		10f. Zip (code	2161	3	10	y. GIII2 0 11 01	USA	may:
death with the ms 23a or 28a	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S. 13.	Was Decede	nt of His			ecify Yes or No- Rican, etc.)		ice - Amer	ica <i>n</i> I <i>n</i> dian,
	Fun	1 Never Married 2 Married	Armed Forces?	No					Rican, etc.)		ack, White	
Ours a	Ď	3 ☐∰Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	A.No	Specify:				ify: wh	
d 21215-0036 filed within 72 hours after Hygiene. thar than "naturer, or He int, It's Modical Examina	Completed	15. Decedent's Ed (Specify only highest grad	ucation de <i>completed)</i>	(Give	dent's Usual kind of work	done d	urina mosi	t of worki		6b. Kind of I	Business/li	ndustry
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ind 212- be filed within tal Hygiene. d other then event, ITE M	Co	11 17. Father's Name (First, Middle, Last)		1 10	O CCCII			er's Name	e (First, Middle, M			
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Maryland 2121. nd 2 should be filed within lith and Mental Hygiene. 27 Is marked other than "retaumatic event, ITE MES	-	19a. Informant's Name/Relationship (7	ype, Print)		-				al Route Number,		n, State, Zi	ip Code)
and 2		Bonnie Willey	p.r.		. Box		, Bet					
Baltimore, oermit. Pages 1 ar Department of Heal mportant: If item: my injury or othan once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from State	20b. Place of Disp cemetery, cre	matory or oth	er place				0c. Location	i - City or 1	Town, State
Lim Pag Iment tant:		* 4 □ Donation 5 □ Other (Specify)	Old Trin	_		_=		13/09	Churc	n Cre	ek, MD
Baltimore, Maryla permit. Pages 1 and 2 should Department of Health and Men Important: If tiem 27 la marke any injury or other traumatic once.		21. Signature of Funeral Services Licen	See		2. Name and			TI	omas Fun			
_ 00200		23a. Part1. Enter the disease, or comp	lications that caused						mbridge,		21613	Approximate
Dissolution		shock, or heart failure. List only of fmmediate Cause (Final	one cause on each fi	ne. Nováscula			,					Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a.	a consequence of):	- U.S.S.	Glade 1 Col						JEROS
Examiner		Convention for any distance	Hyper	terision								years
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687 tifficate g phys as the			d									
Box 68' leath certificat attending phy	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		¬					23d. E	ate of deli	very
death death of for	icia	in the past 12 months? 1 ☐ Yes 2 ☑ No	4☐Pregnant a		□Ectopic pre □ Other (spe					N	<i>Non</i> th	Day Year
P.O.	hys	9 Unknown	9□ Unknown						y			
S, F es tha igned be del	by Physician/Med	Part If. Other significant conditions of	ontributing to death b	out not resulting in the	underlying ca	use give	en in Part I	l.		accouseco s 2 □ No		the cause of death?
cord * require been si	ted	- Personson	(35.19) <u>1</u>	76					1 Ye	5 2 100	3 LIFT	Shabiy 4 Sonkilowii
Vital Records, siclan: The law requires to certificate has been signed rector, page 2 should be	Completed	A13hemens	demente	-				-	24a. Was ar autopsy perform		prior to death?	topsy findings available completion of cause of
al Re										No No	1 Yes	2 No
f Vital F nysiclan: Th his certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe			h (Check only one			
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On C Iding F th. : After	tion	Vatural 5 ☐ Pending 2 ☐ Accident investigation		y Year) Injury	м		<br Yes 2 🗌	No				
Division or Attending after death. Diractor: After	ifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	286. Place of in	jury - At home, farm, s c. (Specity)	treet, factory,	office			28f. Location (Str. City or Town	eet and Nur State)	nber or Ru	ral Route Number,
Dir rs afte al Dir ed in	Certification:	- Carrondo	Dailding, 0	(Optiony)					,			
Division of Vital Records, P.O. Box 68 To the Hospital or Attanding Physician: The law requires that the death certifica within 24 hours after death. To the Funaral Diractor: After this certificate has been signed by the attending phompial prince of the funeral director, page 2 should be detached for use as it completely filled in by the funeral director, page 2 should be detached for use as it.	icai	(Check only 2 Medical Exan	niner: On the basis of	of my knowledge, dea of examination and/or i	th occurred a	it the tim	ne, date ar pinion, des	nd place, eth occur	and due to the ca	use(s) and i	manner as e, and due	stated. to the cause(s)
the h	Medical	one) 29b. Signature and title of certifier	and manner st				e number					h, Day, Year)
To COI		255. Signature and title of certifier	MAX	7 mo	230.	17	75	92	3	8	,10.	09
10		30. Name and address of person who	completed cause of	leath (Item 23a) (Type	Print)	1	har the sale	1-/		1	12	
V		Michael Cro	wey in	610 1	aldes	2711	15/	ino	EASI	27.1	M)	21601
Sta	te	31. Date filed (Month Day Year)	32. Regist	rar's Signature	1	1	y		,,,,			
Regist	ar	WOG 127	Wer Sens	un B. A	park							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Ye ar **Physician** Month 7:15 AM August Sara Louise Highby 07 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Memorial Hospital Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 🗆 M Director 579-34-9509 <u> April 26, 1919</u> New Jersey Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show unit. If item 27 is marked other than "natural", or items 2 and 28a-f show unit of hear it in a large and it is a large and it is a shown and it is a large and it is a 10d. Inside City Limits 10a. State 10c. City, Town or Location 'natural", or items 23a or 28a-f show digal Examinar must be notified at 1 X Yes 2 □ No Director Maryland Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 830 West 40th St. 21210 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∏Yes 2 ∏No If Yes, Give X Year or Dates; 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: ð Specify: White 3 Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 School Teacher Board Of Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Penn Jameson Sara Compton Warren ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important; if item 27 any injury or other tr John Highby 830 West 40th St., Baltimore, Md.21210 son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Aug. 8, 200 Metropolitan Funeral Service 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify, 22. Name and Address of Facility Williams Funeral Home, P.A. 21. Signature of Funeral Service M00668 4270 Hawthorne Rd., Indian Head, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Third Gastrointestinal Hemorrhage of unknown origin **Physician** One hour disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day 5 ☐ Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 □ Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 ∕No Hospital 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

within 24 hours after death

To the Funeral Director: of the Funeral Director: of the foundation of th within 24 hours a

> State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

Thyke 31. Date filed (Month, Day, Year) 32. Registrar's Signature

M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUG 112009

and manner stated

M.D., Dept. of Medicine, Union Memorial Hospital, 201 E. University Pkus Baltimore, MD_21218

29d. Date signed (Month, Day, Year) August, 07, 2009

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

AT 2438946

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2009 8:55 PM August Mary Healy /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Crofton Crofton Convalescent and Rehab. Ctr. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2X F 267-59-5849 84 1925 Northern Ireland 3, Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show other traumatic event, the Medical Examiner rount be notified at 1 □Yes XXNo Director Crofton MD Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö 21114 United Kingdom 1668 Albermarle Dr. items 23a Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 **M**No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White ò 1 ☐Yes 2 No Specify þ 3℃Vidowed 4 □ Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) filed within 72 (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker es 1 and 2 should be filed w of Health and Mental Hygier f item 27 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret McAleese Robert Sloan ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1668 Albermarle Dr. Crofton, MD 21114 Patricia Fogleman / daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 2 Removal from State 1 🗌 Burial 8/7/2009 Baltimore, MD Bayview Crematory 5 Other (Specify) 4 Donation Beall Funeral Home 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 6512 NW Crain Hwy. Bowie, MD 20715 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or confolications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): tructive Pulmonary Distance Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transi and Due to (or as a consequence of) andio Vascular Distan P.O. Box 68760 attending physician for use as the buria certificate be Physician/Medical IF FEMALE ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Day 5 Other (specify) cate has been signed by the a page 2 should be detached to 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No certificate 2 No 1 ☐ Yes 1 Yes To the Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 **X** No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? After (Month, Day, Year) 17 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical and manner stated

State

30. Name and address of person who completed

8

Registrar DHMH 17 Rev 1/2001 29c. License number

ath (Item 23a) (Type, Print) LANT FOX LN# 222

20108

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 900 A M 4c County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Montgomery Takoma Park Washington Adventist Hospital 9. Birthplace (State or Foreign 8. Date of Birth 10/09/1907 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, Days Hours Months Washington, DC 1 □ M 2 F 101 579-58-3571 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h. County 1 √ Yes 2 □ No Silver Spring Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20904 3122 Gracefield Road #CT106 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Specify: White 1 Never Married 2 Married 1 ☐ Yes 2 X No 3 ₩idowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) DC Public Library Department Director 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Annette Euphemia Paige Charles Hart Magill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9329 Harvey Road Silver Spring, MD 20910 Charles Nalls / Nephew 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ¥XBurial 2 ☐ Cremation 3 ☐ Removal from State Glenwood Cemetery 08/15/2009 Washington, DC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service Lic 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 🖺 No 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ♥ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 ☑ No 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. May er of Death 1 Natural 28b. Time of Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Division of Vital Records, P.O. Box 68760, attending physician for use as the buria signed by the a certificate has the irector, page 2 s director, After t

Examine Physician/Medical ≨ Completed Be Certification: To

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Pages 1 and 2 should be filed within 72 hours after unent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or iter

7 is marked other than "nature traumatic event, the Medical

Department of Health Important; If item 27 any injury or other transmission

Physician

/Medicai

Baltimore, Maryland 21215-0036

2 Accident

3 Suicide

30. Name an

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112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier 29b. Signature and title of certific

5 Pending investigation

6 ☐ Could not be

and manner stated 29c. License number

address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

00064024

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

20912

28f. Location (Street and Number or Rural Route Number, City or Town, State)

MD 7600 CARROLL AVET

State Registrar 31. Date filed (Month, Day, Year) AUG 10 ACHTCHININA

		-	For State	State	of Maryla		rtment of F	lealth and M	-				
27	14		Registrar 1. Decedent's Name (First, Middle	2. Date of Deat	h 2	100	3.:Time of Death						
	sicia	1.0	, , , , , , , , , , , , , , , , , , , ,	Emanuel	Havnes				Month August			4:15 aM	
	edic:		4a. Facility Name (If not institution				4b. City, Town, o	r Location of Death		4c. County		-	
			6404 Ear11	nam Drive			1	Bethesda			Mont	gomery	
Fune	ral		5. Social Security Number	6. Sex	7. Age (In yr	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp	lace (State or Foreign	
Direc	tor		131-09-7976	1 3 M 2 □ F	92	Yrs.			October 1			ew York	
pue		-	Usual Residence of Decedent 10a. State 10b. County		10c. (City, Town or Lo	cation				1	0d. Inside City Limits	
Aaryla Fsho	200	9				,,		Bethesda				1 ☐ Yes 2 🛣 No	
the 1		Director	Maryland Mont		10f. Zip Code	bethesua	1	10g. Citizen of What Country?					
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death ms 2:	5	Funeral	11. Marital Status	12. Was Dec	pedent Ever in	U.S. 13. \		lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-		e - Americ	an Indian,	
or iter			1 ☐ Never Married 2 Marr	ied Armed F	orces? 2 🛣 No live				Hican, etc.)		ck, White,	etc.	
2-UU36 72 hours af natural", or	LYG	by	3 ☐ Widowed 4 ☐ Divorced	Year or I	Dates:		I∐Yes 2.1XINo	Specify:		Specif	y:	White	
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nd ZIZI e filed within al Hygiene.			17. Father's Name (First, Middle,		+		Enginee		National Science Foundation ne (First, Middle, Maiden Surname)				
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Aarytan 2 should be and Mental 1s marked of		၉ .	19a. Informant's Name/Relations	Max Hymawit hip (Type, Print)	<u> </u>	19b. Mailir	g Address (Street	and Number or Rui			. State, Zip	Code)	
Manual Indian In	E		Richard Haynes	_		11509	Lake Potor	mac Drive,	Potomac. M	arvland	20854	,	
IOTCE, Maryland 212.15-00036 ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene. If them 27 is marked of their than "natural", or items 23a or 28a-f show what training the notified as			20a. Method of Disposition			. Place of Dispo		i		20c. Location		own, State	
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Daltimor permit. Pages Department of Important: If its	once,		21. Signature of Funeral Service	Licensee	00	22	. Name and Addre		omo Inc				
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	=		23a. Part1. Enter the disease or shock, or heart failure. List	complications that only one cause on	caused the de	ath. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory arr	est,		Approximate Interval Between	
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/Medic Examir	10000		resulting in death)		(or as a cons								
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be executed ician and	1-13	Examiner	that initiated events resulting in death) Last	c	o (or as a cons	equence of):							
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Attending r death.	a la	ical	3 Suicide 6 □ Could	not be 280 Plac	e of injury - At	home, farm, str	eet, factory, office	1100 2 1100	28f. Location (S	treet and Num	ber or Rura	al Route Number.	
after Dire		Certification:	4 ☐ Homicide determ	buil	ding, etc. (Spe	ecify)			City or Tow	n, State)			
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he Hc n 24 i	Diagram I	Medical	(Check only 2 Medical one)		basis of exam nner stated.	ination and/or in	vestigation, in my	opinion, death occu	rred at the time, o	ate and place	, and due t	o tne cause(s)	
A Continent of the part of the									ed (Month,	Day, Year)			
5			100/1	rent	MD			D34590		Augus	t 8, 2	009	
			30. Name and address of person	· ·									
			Roy Elliot Fri	ed, M.D., 6	430 Rock	ledge Dri	ve, Suite	470, Bethes	da, Maryla	ınd 20817	<u>'</u>		
Rec	Stat gistra		31. Date filed (Month, Day, Year)	2009 Jen	negistrans Sig	A. Sa	Red						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Physician AUGUST 2009 10:23 ROBERT /Medical HINES 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 9. Birthplace (State or Foreign 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 € M 2 □ F May 14, 1941 Florida 265-60-3611 68 Director Usual Residence of Decedent 10d Inside City Limits 10b. County 10c. City. Town or Location 10a State 28a-f show other traumatic event, the Medical Evan front rough be notified at Frederick Maryland Frederick 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö USA 21703 5661 Farmhouse Drive items 23a Funeral hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 11 Marital Status 1 ☐ Never Married 2 ☑ Married **Black** Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 21 No Specify Specify. þ 3 Widowed 4 Divorced Year or Dates: Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Medical Laboratory technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) es 1 and 2 should be filk of Health and Mental Hi fitem 27 is marked oth Be Rebecca Reid Robert Hines, Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21703 5661 Farmhouse Drive, Frederick, Maryand Vivian Hines - wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages 1 a Department of He Important: If iter any Injury or oth 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet Cemetery 8-15-2009 Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Home nature of Funeral Service Licenses narow 1621 Opossumtown Pike, Frederick, Maryland 21703 alla Panelle Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Day ANGXIC-Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner COLOHOLIA Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and burial-trai Due to (or as a consequence of) P.O. Box 68760, signed by the attending physician be detached for use as the buria death certificate be Physician/Medical as IF FEMALE: use 23c. If ves, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) I∐Yes 2□No 9 D Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably > Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 255 No has certificate 2 🗆 No 1 ☐ Yes 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification per period outpletely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA ဂ္ 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year)

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State Registrar 31. Date filed (Month, Day, Year) AUG 11 2009

Tanen

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



Frederick

29c. License number

21702

MD516

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P.O. Box 68760, of Vital Records, Division

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any linjury or other traumatic event, if a Medical Examination is consecuted. Baltimore, Maryland 21215-0036 **Physician** /Medical **Examiner** To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlar-transit Medical Certification: To 27. Manner of Death Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00026024 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ster mills St NE washington varnum MD 1160 31. Date filed (Month, Day, 32. Registrar's Signature State AUG 1 1 2009 Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

			State of Maryland / Department of Health and No. 20c. PerFHP008–18–09cr Certificate of Death		Jiene Jieg. No. 200	9 27209	
	Physicia		1. Decedent's Name (First, Middle, Last) Sherry James	2. Date of Dear August		3. Time of Death 3:30 PM	
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Fort Washington Medical Center Ft. Washington		4c. County of Dea		
/	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		I O Bi-	thplace (State or Foreign Duntry) Ohio	
	Director		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	T CD 5	1307	10d. Inside City Limits	
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	h with th	al Dire	10e. Street and Number 1501 Owens Road 10f. Zip Code 20745	1	U.S.A.	ountry?	
036	172 hours after death with the Maryland "natural", or items 23a or 28a-f show calcal Even fine must be nutflied at	by Funeral	11. Marital Status 1	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: B]	e, etc.	
9500-9121		Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Paralegal	king	16b. Kind of Business		
yland 2	other /ent,	To Be Co		ne (First Middle, i esta Wa	Maiden Surname) TKINS		
Zaz	and 2 should be saith and Menta 127 is marked er traumatic ev	-	19a. Informant's Name/Relationship (Type. Print) Roderick A James - Husband 1501 Owens Road, Ox	ral Route Numbe xon Hil	r, City or Town, State, 1 MD 20	Zip Code) 745	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 Is marked any Injury or other traumatic esone.		20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Lincoln Cem	2009	20c. Location - City or Brentwood Suitland	, MD	
Ball	permit. Depart Import any Inj once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility DL 2019 MLK Jr Ave	McLaugh SE Was	nlin Fune shington	ral Home DC 20020	
d'	Physician /Medical		20a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Breast Cancer a. Due to (or as a consequence of):	or respiratory an	rest,	Approximate Interval Between Onset and Death Months	
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08/00,	ificate be executed g physician and as the burial-transit	af Examiner	Sequentially list conditions, if any, leading to immediate cause. Either Unitaritying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):				
X Q Q	ath certi attending for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ 9 □ Unknown		23d. Date of de Month	Date of delivery Month Day Year	
cords, P	quires that in signed build be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		obacco use contribute f 'es 2 □ No 3 □ F	o the cause of death? Probably 4 ☑ Unknown	
я жесо	To the Hospital or Attending Physician: The law requires that the de within 24 hous after death. Within 24 hous after death. completely filled in by the funeral director, page 2 should be detached	Completed		24a. Was a autop perfor	sy prior to death?	utopsy findings available completion of cause of	
т Уптан	hysiclan his certifi I director	To Be	examiner	th <i>(Check only or</i> ome 5 ☐ Resid	ne) lence 6 □Other (Sp	ecify)	
Vision of	tending Pleath. or: After the funeral	Certification:	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be	28d. Describe h	ow injury occurred		
	ital or At ins after d ral Direct led in by	Certifi	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	Rireet and Number or F rn, State)	Rural Route Number,	
	he Hosp in 24 hou he Funei pletely fil	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place and plac				
	To t with To t	Ž	29b. Signature and title of certifier A. M. Alelele W 29c. License number 4.604		29d. Date signed (Mdr.	2009	
	3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Amir Mirza-Alikhani Ft Washington Med Ct	1171 cr Ft.		ston Road on MD 20744	
	Sta	te	31. Date filed (Month, Day Year) 32. Registrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2009 12:05 P.M Aaron Wallace August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2900 Kingsway Road Fort Washington Prince Georges If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Yeal 950 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days 1 X M 2 □ F 59 578-66-2213 January 28, Washington,D.C. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Fort Washington Maryland Prince Georges 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20744 2900 Kingsway Road United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 □Yes 2 X No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2 years Electrician U.S.Department of Army 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Richard Henry Jackson **Alice** Virginia Jackson 19a. Informant's Name/Relationship (Type. Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheila Melinda Massie Jackson 2900 Kingsway Road; Fort Washington, Maryland 20744 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4☐Donation 5 ☐Other (Specify) Fort Lincoln Cemetery Brentwood, Maryland

Physician /Medical Examiner

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Physician

/Medical

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Funeral

Director

28a-f show

ral", or items 23a or 28a-f shov Examiner must be notified at

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Completed

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Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

Medical Certification: To Be Completed by Physician/Medical Examine

or Attending Physician; The law requires that the death certificate be executed

cate has been sign page 2 should be

Division of Vital Records, P.O. Box 68760,

23a. Part1. Enter the disease, or con shock, or heart failure. List only	pplications that caused the deat	1 -		<u>-</u>		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition	_a Metastatic	Duodenal Ca	ancer			7 years
resulting in death)	Due to (or as a conseq	juence of):				
Sequentially list conditions, if any, leading to immediate cause. Line Underwing Cause (Disease or injury	b. Due to (or as a conseq					
Cause (bisease or injury that initiated events resulting in death) Last	c	uence of):			 	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregns 1 Live birth 2 Fete 4 Pregnant at time of o	al death 3 Ectopic pr			23d. Date of d Month	elivery Day Year
Part II. Other significant conditions	contributing to death but not res	ulting in the underlying ca	use given in Part I.			to the cause of death? Probably 4 🛣 Unknown
			- y - Name	24a. Was an autopsy performe 1 □Yes 2 ■	d? death?	autopsy findings available completion of cause of
25. Was case referred to medical examiner?				ath (Check only one)		
1 ☐ Yes 2 🛣 No	Hospital: 1 Inpatient 2 I	ER/Outpatient 3 DO	A Other: 4 \(\sum \) Nursing I	Home 5 🔀 Residen	ce 6 □Other (Sp	pecify)
27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigatio		28b. Time of Injury M	Bc. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how	injury occurred	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		ome, farm, street, factory, fy)	office	28f. Location (Stre City or Town,	et and Number or I State)	Rural Route Number,
29a. Certifier (Check only one) 1 △ Certifying P. 2 ☐ Medical Exa	hysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, death occurred ation and/or investigation,	at the time, date and place in my opinion, death occ	ee, and due to the cau urred at the time, date	se(s) and manner e and place, and di	as stated. ue to the cause(s)
29b. Signature and title of certifier	-10	29c	License number	290	. Date signed (Mor	nth, Day, Year)
Sprilier 1	6- Tutna	MD	MD33037	A	ugust 7	, 2009

State Registrar

within 24 hours after death.

To the Funeral Director: A!

Andrew Tyler Putnam, M.D.; Georgetown University Medical Center; Washington, D.C. 20007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3800 Reservoir Road, N. W.

The second of the significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 No 9 Unknown 9 Unknown 1 Yes 2 No 3 No 3 No Probably 4 Unknown 1 Yes 2 No 3 No 3 No Probably 4 Unknown 1 Yes 2 No 3 No 3 No Probably 4 Unknown 1 Yes 2 No 3 No 3 No Probably 4 Unknown 1 Yes 2 No 3 No 3 No Probably 4 Unknown 1 Yes 2 No 3 No 3 No Probably 4 Unknown 1 Yes 2 No 3 No 3 No Probably 4 Unknown 1 Yes 2 No 3 No 3 No Probably 4 Unknown 1 Yes 2 No 3 No Probably 4 Unknown 1 Yes 2 No 3 No Probably 4 Unknown 1 Yes 2 No 3 No Probably 4 Unknown 1 Yes 2 No 3 No Probably 4 Unknown 1 Yes 2 No 3 No Probably 4 Unknown 1 Yes 2 No 3 No Probably 4 Unknown 1 Yes 2 No 3 No Probably 4 Unknown 1 Yes 2 No 3 No Probably 4 Unknown 1 Yes 2 No 3 No Probably 4 Unknown 1 Yes 2 No 3 No Probably 4 Unknown 1 Yes 2 No 3 No Probably 4 Unknown 1 Yes 2 No 2 No Probably 4 Unk				1 - For State Registrar	State of M	arylan		artment of F rtificate of		and M		giene Reg. No.	ano	2.7	211
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Physician Medical Examiner Ph	g	Impo any once		ille May was	10/101	1								6	
Physician Medical Examiner Page 200 Page 300		,		23a. Part 1. Enter the disease, or com	plications that cause	d the death							2074	Approxima	ate
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Sequentially list conditions, Eastern Underlying Cause. Enter Underlying Cause		/Medical			a			scasc							<u> </u>
Cause. Enter Underlying Cause and Check only one part of the past 12 months? IF FEMALE: 23d. Date of delivery Month Day You always from the past 12 months? 1 Use brint 2 Felal death 2	E	xaminer	L	Sequentially list conditions.	D			r						<u> </u>	
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30. Name and address a person who completed cause of death (Item 23a) (Type, Print)	•	8		30. Name and address person who	completed cause of				. 505			0, 1.	-, 2007		
Heather Lee, MD 4901 Telsa Dr. Suite A. Bowie, Md. 20715			1	Heather Lee, MD	4901 Tels	a Dr	, ,	,	owie,	Md.	20715				
State 31. Date filed (Month, Day Year) 32. Registrar 32. Registrar 33. Date filed (Month, Day Year) 32. Registrar 33. Date filed (Month, Day Year) 33. Registrar 33. Date filed (Month, Day Year) 34. Registrar 35.				31. Date filed (Month, Day (32)	32. Registr	's Sign	ale								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Пау Month Physician Rose O. Jackson 2009 80 01 6:00p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Thomas More Prince Georges Hyattsville 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 1 □ M 2 🖾 F Months Hours 578**-**60-1471 80 01/02/1929 South Carolina Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Director DC Washington 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20011 6119 7th Place, NW United States Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2**▼** No African 1 ☐ Yes 2K No Specify Specify <u>ک</u> 3 Widowed 4 Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Intelligence 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alamo T. Oliphant Faith Lewis ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffrey Jackson/Son 6119 7th Place, NW, Washington, DC 20011 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Chesapeake Crematory 8/10/2009 | Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral 22. Name and Address of Facility McGuire Funeral Service, Inc. ricensee Keta 7400 Georgia Avenue, NW, Washington, DC nances 20012 CC0506 23a. Part1. Enter the dise s / or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail re. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HRIERLOSCLEMONIC ARDIOVASCUL eare Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):

Physician /Medical **Examiner**

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To the Funeral Director: After completely filled in by the funera To the Hospital or Attending within 24 hours after death.

within 2. To the I

certificate be executed

Box 68760,

Records, P.O.

Division or Vital

Funeral

Director

28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Examine Physician/Medical

þ

Completed

Be

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Certification:

Medical

IF FEMALE: 23b. Was decedent pregnant 9 Unknown

in the past 12 months? 1 ☐ Yes 2 ☑ No

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death

9∏Unknown

5 ☐ Other (specify)

3 □Ectopic pregnancy

23d. Date of delivery Month Day

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

23e. Did tobacco use contribute to the cause of death?

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

MOURING HYPORTENSIO Congestive Heart Pailone

Wronic Renal 25. Was case referred to medical examiner?

6 Could not be determined

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 5 Pending investigation

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

Other: 4 Vursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

2 No

24a. Was an

1□ Yes

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

29a. Certifier

1 ☐ Yes 2 ☐ No

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

4 Homicide

29b. Signature and title of certifier

Karcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

4203 Queensbury Rd Hug Haville MD 20151 Mos 31. Date filed (Month, Day, Year) Registrar's Signature

State Registrar

			For State Registra			State o	f Marylar		artment					giene Rag. No	0 0 9	27213
	_			Name (First, Midd	(le Last)			- 00	rimoute				2. Date of De	ath		3. Time of Death
	Physicia	an	How		Ki	na							Month Aug.	Day	2009	10:33 ам
è	/Medic			me (If not institution			mber)		4b. City.	Town, or	Location	of Death		4c. Co	unty of Death	
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			5. Social Secu		6. Sex		7. Age (In yrs.	last birthday	If Under	1 Year	If Under	24 Hrs.	8. Date of Bir	th.	9. Birth	place (State or Foreign
	Funeral Director			2-6842		4 2□F	74	Yrs.	Months	Days	Hours	Min.	Jan. 21	", " 193	5 Fauq	uier Co.,VA
			Usual Reside	nce of Decedent					<u> </u>							
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	r 28	irec	10e. Street ar	nd Number					10f. Zip	Code				10g. Citize	n of What Cou	intry?
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	within 72 hours after death with the Maryland ene. then "natural", or lleme 23a or 28a-f ehow fra Madeal Examinar must ke notified at	Funeral Director	11. Marital St	atus	12	. Was Dec	edent Ever in U	J.S. 13.	Was Deced	ent of Hi	spanic Or n, Mexical	igin? (Sp n, Puerto	ecify Yes or No Rican, etc.)	- 14	Race - Amer Black, White	
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8	ural',	d by	3 🗌 Wido	wed 4 Divorce		Year or D	ates:				41			16h Kind	of Business/l	
5	72 h	Completed		15. Decede (Specify only high	est grade	ation com <i>pleted)</i>		(Give	edent's Usua e kind of wo DO NOT us	rk done d	during mos	st of work	ing	100. Kalo	OI DUSINESSEI	ridustry
2	Athin of the state	E D		//Secondary (0-12)		College (1-4or 5+)		iance			nic		Mec	hanic	al
2	Hygie Hygie other			Name (First, Middle	a. Last)			I F F					e (First, Middle			
Maryland 21215-0036	g g p ≥	Be		∋у Т. К							Add	die	Timber	s Ki	nq	
2	should nd Mer marke umatic	2		nt's Name/Relatio		e Print)		19b. Mail	ina Address	(Street			al Route Numb			(ip Code)
Ma	d2 sith and 7 io t			G. Kir												MD 20901
ď	Heelt Heelt Her ther		20a Method	of Disposition			20b.	Place of Disp	osition (Nar	ne of	1		Date		tion - City or	
Baltimore,	nges nt of l		1 🗺 Buri	al 2 Cremation		moval from	State MI	Nebo B				8_15	5-2009	Moro	antow	n. VA
Ë	it. Pi			ation 5 Other					_		1		yles F			
Ba	permit. Pages Depertment of I Important: if ite eny injury or of		21. Signatur	2) in		KIM	Ou .						llville			
			23a Part1	Enter the disease,	or complic	ations that	caused the dea							•	, <u></u>	Approximate
			shock, Immediate C	or heart failure. L	st only one	cause on	each line.									Interval Between Onset and Death
	Physician		disease or c	ondition	a.		nd-	Stag	je v	en	al	di	sease	١		6 months
	/Medical Examiner					Due to	(or as a conse	equence of):	,							
		<u></u>	Sequentially	list conditions.	b.		(or as a conse	quence of).								
1	ted nsit	Examiner	cause. Ente Cause (Dise	ng to immediate or Underlying ase or injury	≺											
<i>_</i>	be executed icien and burial-transil	хаг	that initiated resulting in o	events	C.	Due to	(or as a conse	quence of):								
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68760,					0.											
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ŏ	ette d for	ciai	in the p	past 12 months?		4□Preg	birth 2∏Fe inant at time of		□Ectopic p □ Other (s)		<i>'</i>				Month	Day Year
P.O.	by the de	ysi	9 □ Un			9□ Unki	nown									
T	res thet igned b	by PI	Part II. Other	r significant cond	itions con	tributing to	death but not re	sulting in the	underlying o	cause giv	en in Part	: 1.	23e. Did	tobacco us	1	the cause of death?
ds	luires n sign	D D											1 🗆	Yes 215	No 3□P	robably 4 Unknown
of Vital Records,	w require been si should b	Completed											24a. Wa		24b. Were a	utopsy findings available completion of cause of
Re	The lav	E												opsy formed2 2 2 No	death?	
a	in: T	Ö	25 Was cas	se referred to med	cal				-		26 Plac	ce of Dea	th (Check only			
Ē	ysician: is certific director,	To B	examine		plant of the last	ospital:	Inpatient 2	☐ ER/Outpati	ent 3 D	OA Ott			ome KRe		☐Other (Spe	ecify)
ō	Phy er this		27. Manner	of Death		28a. Date	of Injury oth, Day Year)	28b. Time Injury	of	28c. Inju	ry at		28d. Describe			
o	nding I ith. : After s funer	i i	ty⊠Natu 2 □ Acc		ding stigation	(MO	nui, Day 19ai/	IIIJuiy	м		Yes 2[□No				
Division	Atte	150	3 ☐ Suid	dot	ld not be imined		e of Injury - At		street, factor	ry, office			28f. Location City or T	(Street and	Number or R	lural Route Number,
ā	s efte	Certification:	42110	moido		00	aling, oto. (Opo	o.i.y7				3				
	To the Hospital or Attending Physician: The law requires thet the death certificat within 24 hours effer death. To the Funeral Director: After this certificate has been signed by the ettending phy completely filled in by the funeral director, page 2 should be detached for use as the		29a. Certifie	or Certif	ying Phys	ician: To th	ne best of my k	nowledge, de	ath occurred	at the ti	me, date a	and place	, and due to th	e cause(s)	and manner a	s stated. e to the cause(s)
	n 24 n 24 he Fu	Medical	one)			and ma	nner stated.									
	To t To t	Σ	29b. Signati	ure and title of cert	ifier		.esii				se numbe					th, Day, Year)
	1		•	Sydn	つ レ	Ino	711	7316	1440	P	フ う ら	10		Hyo	WS+	10,209
)		30. Name a	nd address of pers	on who co	mpleted ca	use of death (II	em 23a) (Typ	e, Print)	62	4	7	BRUAT	may		10,2009
_				H-1 D-	^	\V	KOON	~ 00	"		721	447	MORE	MD	212	v 5
		ate		ad (Month, Day, Ye	ar)	34.	Registrar's Sig	naure &	u Kal							
	Regist	trar		AUG I	ZUUS	Ken	and ,	13. 1916	1							

	1 _ State	artment of Health and Ment rtificate of Death	Reg. No.			
Physician	1. Decedent's Name (First, Middle, Last)	2. D	Oate of Death Month Day Year 3. Time of Death			
/Medical Examiner	Blanche Hyatt Keller 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	gust 09, 2009 12:50 P M 4c. County of Death			
	Casey House-Montgomery Hospice 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Rockville If Under 1 Year If Under 24 Hrs. 8, D	Montgomery Date of Birth Month, Day, Year) 9. Birthplace (State or Foreign Country) District			
Funeral Director	579-54-4410 1	Months Days Hours Min. (1)	Date of Birth Month, Day, Year) /12/1940 9. Birthplace (State or Foreign Country) District of Columbia			
Maryland I-f show Ind at	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo Maryland Montgomery Gaithers		10d. Inside City Limits 1 □Yes 21 No			
vith the Mar. t or 28a-f st be notified Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?			
items 23a	911 Wild Forest Drive 11. Marital Status 1 □ Weser Married 2 □ Married 1 □ Yes 2 □ Who	20879 Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ricar	Yes or No- n, etc.) 14. Race - American Indian, Black, White, etc.			
d 2 should be filed within 72 hours aft th and Mental Hygiene. 27 Is marked other than "natural", or traumatic event, tra Medical Evant To Be Completed by F	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 Yes 2 No Specify: dent's Usual Occupation kind of work done during most of working	Specify: White 16b. Kind of Business/Industry Bureau of Health			
led within 72 hou tygiene. her than "naturant, the Model	Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of working DO NOT use retired) or Advisor 18 Mother's Name (Fir	Professions st, Middle, Maiden Surname)			
uld be fill Mental H arked oth artic even	John Ellwood Keller	Mary Eliza				
12 shouh and N		ng Address <i>(Street and Number or Rural Ro</i> 0 Comus Road Clarksb	oute Number, City or Town, State, Zip Code)			
mit. Pages 1 and partment of Healt portant: If item 21 y injury or other 12.	20a. Method of Disposition 20b. Place of Disposition	osition (Name of matory or other place) Date August	20c Location - City or Town, State			
Page tment c tant: If jury or	1⊠Burial 2 □ Cremation 3 □ Hemoval from State 4 □ Donation 5 □ Other (Specify) Fort Linc	oln Cemetery 2009	Brentwood, Maryland			
permit Depar Impor any in		2. Name and Address of Facility DeVol 0 East Deer Park Dri	ve Gaithersburg, MD. 20877			
Coate be executed physician and physician and physician and the burial-transit the burial-transit edical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Carcinosarcoma Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):					
To the Hospital or Attending Physician: The law requires that the death certification after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as it medical Certification: To Be Completed by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 4 □ Pregnant at time of death 5	□ Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year			
un signed build be deta	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 M Unknow			
al or Attending Physician: The law requires the after death. I Director: After this certificate has been signed in by the funeral director, page 2 should be constituted in the funeral director.	25. Was case referred to medical	26. Place of Death (C	24a. Was an autopsy performed? 1 □ Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?			
rs after death. Is after death. In Director: After this cered in by the funeral direct Certification: To B	examiner? 1		g Home 5 Residence 6 Mother (Specify) Hospice 28d. Describe how injury occurred			
ital or Atter ins after dea ral Director lled in by the	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		Location (Street and Number or Rural Route Number, City or Town, State)			
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in Medical Cerl	29a. Certifier (Check only one) 1X Certifying Physician: To the best of my knowledge, deal on the basis of examination and/or and manner stated.	ath occurred at the time, date and place, and investigation, in my opinion, death occurred a	d due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)			
To the complete of the complet	29b. Signature and title of certifier J. iwweltehou, mD	29c. License number	29d. Date signed (Month, Day, Year) August 09, 2009			
r	30. Name and address of person who completed cause of death (Item 23a) (Type Jocelyne Kouatchou M.D. 1355 Piccard		rvland 20850			
State	21 Date filed (Month Day Year) 32 Registrar's Signature	ares	2,2414 20000			

			For State	State of	Maryland		artment of H			0.0	0.0	27215
_			Registrar 1. Decedent's Name (First, Middle	l act)		Ce	- IIICale OI I		2. Date of Dear	eg. No.	113	3. Time of Death
	Physicia	n	,		77.43.65.4	D			Month	Day	Year 009	2:47 P M
1	/Medic		4a. Facility Name (If not institution	NUKA	KAMDA	ı.K	4b. City Town, or	Location of Death	AUG.	6, 20 4c. County		2:4/ P
	Examin	er	SHADY GROVE			T		KVILLE			ONTGO:	MERY
	Funeral		5. Social Security Number		7. Age (In yrs. la		If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day)		place (State or Foreign ntry)
	Director		189-60-3167	1□M 2 X F	66	Yrs.	Months Days	Hours Min.	MARCH 2	3,1943	IN	DIA
	p		Usual Residence of Decedent								14	0d. Inside City Limits
	arylar show d at	_	10a. State 10b. County		10c. City	, Town or Lo	cation					1 □ Yes 2 □ No
	Ba-f	Director	MD. MONTG	OMERY			GERMANTOV	/N		l0g. Citizen of	Albat Cour	21
	vith th		10e. Street and Number				10f. Zip Code			· ·		nt y :
	s 23s	Funeral	20065 APPL		R. #11 dent Ever in U.S	112	2087		nacify Vas or No-		S.A.	ean Indian
	er de item ner n	Ľ.	11. Marital Status1 ☐ Never Married 2 ☐ Marr	Armed For	ces?	. 13.	Was Decedent of H If Yes, specify Cuba	an, Mexican, Puert	o Rican, etc.)	Bla	ck, White,	
35	hours after death with the Maryland tural", or items 23a or 28a-f show I Evaniner must be notified at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv Year or Da	re -		1 □ Yes 2 □XNo	Specify:		Specif	Y. ASIA	N INDIAN
5-0036	n 72 hours '"natural", odical Exa	ted	15. Deceden	t's Education		16a. Dece	dent's Usual Occup	ation	king	16b. Kind of B	usiness/In	dustry
	hin 7. e. an "n Medi	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	DO NOT use retired	dining most of wor 1)	Kirig			
7	filed within Hygiene. other than '	Con		4			HOUSEWIFE				HOME	
Maryland	be filed htal Hyg ed othe event,	Be	17. Father's Name (First, Middle,					18. Mother's Nan	ne (First, Middle,		ne)	******
<u>ya</u>	should and Men s marke umatic	2	JADEVJ1B		PARIKH	I			CHANCHA		01	UNK.
Z Z	12 sh h and 7 Is n traun		19a. Informant's Name/Relations				ng Address (Street					
	is 1 and 2 should be of Health and Mental Item 27 Is marked or other traumatic ever		PRAVIN KAMD 20a. Method of Disposition	AR/HUSBANI			5 APPLEDO		Date Date	20c. Location		
altımore,	W = 5		1 Burial 2 Cremation		state		osition (Name of matory or other place	i		DILLED) (D
	mit. Pag partment sortant: r injury c		4 □ Donation 5 □ Other (S		CF		S CREMATO Name and Addre			RIVER		
n	Depart Impo		I JUIN-CH	amber	M000	91 5	Name and Addre HAMBERS I 801 CLEVI	FUNERAL H ELAND AVE	OME & CF	REMATOR: RDALE, 1	IUM,P MD. 2	.A. 0737
	The same		23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that conly one cause on e	aused the death ach line.	. Do not en	ter the mode of dyir	ng, such as cardiad	or respiratory ar	rest,		Approximate Interval Between Onset and Death
المحمد	Physician		Immediate Cause (Final disease or condition	a. ACUTI	E MYOCAF	RDIAL	INFARCTIO	ON				MINUTES
	/Medical Examiner		resulting in death)		or as a consequ							777 A D.C.
		-	Sequentially list conditions,	D.	COSCLERC or as a consequ		ORONARY A	ARTERY DI	SEASE			YEARS
	uted J ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			,					1	
oʻ	be executed ician and burial-transit		that initiated events resulting in death) Last	Due to (or as a consequ	ence of):						
3760	cate be executed physician and the burial-transit	lical		d							-	
9	The law requires that the death certificate ate has been signed by the attending phys age 2 should be detached for use as the l		IF FEMALE:	00-16								
Box	eath certific attending p for use as f	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live b	come of pregnal	death 3	Ectopic pregnand	Ey .			ate of deliv onth	ery Day Year
o.	he de the a	ysic	1 ☐ Yes 2 ☐No 9 ☐ Unknown	9 Unkn	nant at time of do own	eaun 5	Other (specify) _					
J.	that the de ned by the a detached t		Part II. Other significant condition	ons contributing to de	eath but not resu	Ilting in the u	inderlying cause giv	en in Part I.	23e. Did to	bacco use cor	tribute to	the cause of death?
Records,	w requires to been signed should be a	d by							1□Y	′es 2□No	3□ Pro	bably 4 Unknown
Ö	v req	lete		-					24a. Was	an 24b	Were aut	opsy findings available
Re	The law cate has page 2 t	Completed								rmed?	death?	ompletion of cause of
		Ö	25. Was case referred to medica	1				26. Place of De	1 ☐ Yes ath (Check only o		1 🗆 Yes	2 No
>	ysicia is cer direct	.O	examiner? 1 ☐ Yes 2 ဩNo	Hospital:	Inpatient 2 🔀	ER/Outpatie	nt 3 □ DOA Oth	or:	lome 5 ☐ Resid		her (Spec	ify)
101	g Phr ter th		27. Manner of Death	28a. Date		28b. Time of Injury		ry at	28d. Describe h	now injury occu	rred	
0	ath. nr: Af	atio	1 Natural 5 Pendir Pendir investi	gation	or, Day, reary	,,		Yes 2□No				
Division	r Atte er de recto	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	pined 28e. Place	of Injury - At ho ng, etc. (Specify	me, farm, si	reet, factory, office		28f. Location (S City or Tov		ber or Rui	al Route Number,
	pital c		29a. Certifier 1 📝 Certifyin	ng Physician: To the	hast of mer tor	wledge de-	th occurred at the t	ime date and place	e and due to the	cause(s) and	nanner as	stated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certifica completely filled in by the funeral director, is	Medical	(Check only 2 Medical	Examiner: On the b	asis of examination and stated.	tion and/or i	nvestigation, in my	opinion, death occ	urred at the time,	date and place	, and due	to the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifie		1	W			_	29d. Date sign	. /	, Day, Year)
	5		tand	Sc. h	Le 1		100	58025	>_	tugus	t 6	2009
			30. Name and address of person	who completed caus						-		
			JONATHAN M. 31. Date filed (Month, Day, Year)		D. 990 Registrar's Signal		ICAL CEN'	TER DR.,	ROCKVILI	LE, MD.	2085	0
	Sta Registr		ALC 11		legistrar's Signal	1. 6	well					

			For State	State of	f Marylan			of Health and	d Mental Hy	ygiene 2	09	2721
			Registrar			Ce	rtificate (of Death	O Data of D	Reg. No.		O Time of Death
	Physici	an	1. Decedent's Name (First, Middle, Dennis E		LOWO				2. Date of D Month	Day	Year	3. Time of Death
-	/Medi	cal	Dennis E 4a. Facility Name (If not institution,		Love		4b City Toy	n, or Location of De	Augus	st 8, 2	009 of Death	1:30a [™]
A STATE OF THE STA	Examir	ier	Potomac Valle		,	tor	,	ville		Monto		7
	Funeral			6. Sex	7. Age (In yrs.		If Under 1 Y			irth	9. Birthpla Country	ce (State or Foreign
	Director		577-52- 4770	1 X M 2 □ F	7	71 Yrs.	Months	ays Hours IVI		8,1938		nsylvani:
	pu "		Usual Residence of Decedent 10a, State 10b, County		10c Cit	y, Town or Lo	ncation				100	I. Inside City Limits
	f sho	ō	,									1 □Yes 2 □No
	the N 28a- notifi	Director	MD Monto	gomery	Br	cooke	Ville 10f. Zip Co	de		10g. Citizen of	What Country	y?
	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ont, the Medical Framiner must be notified at		19412 Rena Co	nırt			208	33		USA		
	death	Funeral	11. Marital Status		edent Ever in U.	S. 13.		of Hispanic Origin? Cuban, Mexican, Pu	(Specify Yes or N	lo- 14. Ra	ce - Americar	
9	after or ite		1 ☐ Never Married 2 ☐ Marrie		2 X No	1	1 ☐ Yes 2 🔯		ierto nican, etc.)		ok, while, ell v: Whit	
003	ours ural",	Completed by	3 Widowed 4 □ Divorced	Year or Da	ates:							
15-	"nati	lete	15. Decedent's (Specify only highest	Education grade completed)		16a. Dece	dent's Usual O kind of work d	ccupation one during most of v etired)	working	16b. Kind of E		•
12	within iene. than	щ	Elementary/Secondary (0-12)	College (1	-4or 5+)		acher	ourou,		Public	_	County
D	be filed with that Hygiene of other the event, the	BeC	17. Father's Name (First, Middle, L		+		201102	18. Mother's N	Name (First, Middle			<i>J</i> U15
<u>la</u>	should be filed and Mental Hygi marked other imatic event, the	To B	Boyd Collins	Love				Delore	es Mari	e Rendi	.ne	
Maryland 21215-0036	07 ET 49 =	1	19a. Informant's Name/Relationsh	ip (Type. Print)		19b. Maili	ng Address (Si	treet and Number or	Rurai Route Num	ber, City or Town	, State, Zip C	Code)
Σ,	1 and 2 Health a tem 27 is		Dennis E. Lov	7e, Jr.	/Son			a Court		·		
Baltimore,	ges 1 art of Heart If Item	!	20a. Method of Disposition 1 Surial 2 ☐ Cremation	3 □ Removal from :			osition (Name of matory or other		Date	20c. Location	•	
ţ	permit. Pages of Inportant: If Ite any injury or of any injury or of once.		4 Donation 5 Dother (Sp	ecify)	Ga	ite o	f Heav	ddress of Facility	ıg. 13, 2009	Silve	Spr.	ing,MD
Bal	Depar mpor mpor any ir		21. Signature of Funeral Service L	icensee	Man			doress of Facility	11		Home	
0			23a. Part 1. Enter the disease, or	om lications that c	aused the death	01051	00 Uni	versity	Blvd.	W.Silve	r Spr	cing, MD
			shock, or heart failure. List of	ne cause on e	ach line.	n. Do not on	ter the mode o	r dyllig, oddir do odre	and or reopiratery	41.000		nterval Between Onset and Death
	Physician /Medical	Ш	disease or condition resulting in death)	_ a	monia (or as a consequ	uongo of\:						
7	Examiner				ure t		ed area					
		je	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events		or as a conse		LIVE					
>	ficate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events	с								
oʻ	e exe	Ä	resulting in death) Last	Due to (or as a consequ	uence of):						
8760,	ate b	dical	,	d								
9	eath certific attending p	Me	IF FEMALE:	23c If you out	come of pregna	ncy				001.0	· -	
Вох	atten for us	ian	23b. Was decedent pregnant in the past 12 months?	1 Live b	oirth 2 ☐ Feta nant at time of c	Ideath 3	☐ Ectopic preg ☐ Other (speci				ate of deliver onth	y Day Year
0	that the de	Physician/Me	1 □Yes 2 □No 9 □ Unknown	9 Unkn								
σ.	s that ned b	y P	Part II. Other significant condition	ns contributing to de	eath but not resi	ulting in the u	inderlying caus	e given in Part I.	23e. Dio	l tobacco use cor	tribute to the	cause of death?
먑	w requires t been signe should be	d b	Advanced Deme	entia					_ 10]Yes 2⊠No	3 ☐ Proba	bly 4 🗆 Unknown
ပ္က	The law requires that the death certifiate has been signed by the attending tage 2 should be detached for use as	Completed by							24a. Wa			sy findings available
æ	The laste has page	E							— aut per 1 □Yes	opsy formed? 2 🛂 No	death?	pletion of cause of 2 □ No
ita	slctan; The certificate rector, pag	Be C	25. Was case referred to medical examiner?					26. Place of I	Death (Check only			
	ys is		1 Yes 2 XNo	Hospital: 1 □ I	Inpatient 2 🗆			Other: 4 X Nursin	g Home 5 ☐ Re	sidence 6 □ O	her (Specify))
ב	ing P	ü	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date (Mont	of Injury th, Day, Year)	28b. Time o Injury		Injury at Work?	28d. Describe	e how injury occu	rred	
Sio	Attending r death. ector: Afte by the fune	cati	2 Accident investiga 3 Suicide 6 Could no	ot he	AA ba		M	1 □Yes 2 □No	20f Logotion	(Chan a train of Aluma	har as Duml	Pouto Number
Division of Vital Records,	or Al after d Direction by	Certification: To	4 ☐ Homicide determin	ned 28e. Place building	of Injury - At ho ng, etc. (Specif	y)	reet, lactory, or	nce		(Street and Num own, State)	ber or Hurar	noute Number,
_	spital ours a leral filled		29a. Certifier 1 XCertifying	Physician: To the	best of my kno	wiedge, dea	th occurred at	the time, date and p	lace, and due to th	ne cause(s) and r	nanner as sta	ated.
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical		xaminer: On the b				my opinion, death o				
	To th within To th	Me	29b. Signature and title of cortifier	ZN	000			icense number		29d. Date sign		
			1 5)	2 "	MA		D	00624	35	8/	0/20	009
	P		30. Name and address of person w							-		
			Sayed Elsayya	id, MD	10110	Mole	cular	Drive, F	Rockvil	le, MD	20850)

State Registrar 31. Date filed (Month, Day, Year) AUG 11 2009

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2009 August 7 11:57 a Jianrong 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Gaithersburg Montgomery 393 West Side Drive, #104 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 1X M 2□ F Yrs. 397-27-6458 China 33 DEC 02, 1975 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 XYes 2 No Montgomery Gaithersburg Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number China 393 West Side Drive, #104 20878 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify Specify: Asian 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Department Elementary/Secondary (0-12) College (1-4or 5+) NIST / of Commerce 5<u>+</u> Research Engineer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Xiuwen Du Yuanfang Li 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 393 West Side Dr., #104, Gaithersburg, MD 20878 Haining Zheng / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Atlantic Crematory 08/17/2009 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thibadeau Mortuary Service, P.A. 933 Gist Ave., LL, Silver Spring, 21. Signature of Fune al Service License M00956 MD 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to of as a nsequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy Year Month Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death?

Pnysician /Medical Examiner

as the l

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certificate

death.

Director:

24 hours a

within 2 To the To the

esn

The law requires that the death certificate be executed

Box 68760,

P.O.

Records,

Division of Vital Hospital or Attending Physician:

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show

Items 23a death

Director

Completed by Funeral

Be

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other treumetic event, the Medical Examinar must be notified at

Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other then "naturel", or Itel

i i o

Baltimore, Maryland 21215-0036

with the Maryland

Examiner Completed by Physician/Medical To Be

25. Was case referred to medical examiner? 27. Manner of Death Certification:

Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 Unknown

Yes 2 No

1 Natural

2 Accident

3 Suicide 4 ☐ Homicide

29a. Certifier

Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed? Yes 2.21 No 1 Yes

26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28b. Time of 28a. Date of Injury (Month, Day Year) Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 2 No

1 ☐ Yes 2 ☐ No

1 Tyes Unto 2009 28 So ce of Injury - At home, farm, street, factory, office building, etc. (Specify) 40000

hanging . 5015 675/10 28f. Lo file (Stre Fand Number or Rural Route Number, City or Town, State) 3 9 3 (CCC) 5 No. D r Gathersburg, MD 20878 704 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Sonature and title of certifier 2

mo DME

29c. License number D00428

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

August 10, 2009 20902

3 ☐ Probably 4 ☑ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

Ira N. Brecher, M.D., F.A.C.S., 2101 Medical Park Drive, #304, Silver Spring, MD

State Registrar 31. Date filed (Month, Day, Year) AUG 11 2009

5 Pending

investigation

6 Could not be determined



		1	State	State of Maryland / Dep Ce	ertificate of D		tal Hygiene	2009	27219
			Registrar 1. Decedent's Name (First, Middle, Last)			2.	Date of Death	Vans	3. Time of Death
	Physicia			owell			Month Day		1538 ^M
	/Medic	-	4a. Facility Name (If not institution, give str		4b. City, Town, or L			County of Deeth	
	Examin	er	Prince Georges H		Chev	verly	P	rince (Georges
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthda)		If Under 24 Hrs. p	Date of Birth (Month, Day, Year)	9. Birth	place (State or Foreign intry)
П	Director		245-80-0479	61 Yrs.	Month's Days	Au	ig. 26, 19		
	pg	-	Usual Residence of Decedent	10c. City, Town or	continu				10d. Inside City Limits
	show		10a. State 10b. County			1 (1 XYes 2 □ No
	8a-f	Director	MD PO	G Ca	pitol He	ignts	10g Citi	zen of What Cou	intry?
	vith ti	吉	10e. Street and Number		10f. Zip Code	4.3			
	s 23s	ara	1108 Jansen Aver		2074			ited Si	
	er de Item	Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married	Armed Forces?	I. Was Decedent of His If Yes, specify Cuban	, Mexican, Puerto Rici	an, etc.)	Black, White	, etc.
36	within 72 hours after deeth with the Maryland ene. than "natural", or items 23e or 28e-f show the Mudical Exatt for must be notified a	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 🔀 No	Specify:		Specify: Bla	ack
5-0036	2 hou	ted	15. Decedent's Educa	tion 16a. Dec	edent's Usuat Occupat	tion	16b. Ki	nd of Business/li	ndustry
215	hin 7.	pie	(Specify only highest grade of Elementary/Secondary (0-12)	Contege (1-4or 5+)	DO NOT use retired)	ning most of working			
7	d with	Completed	11		ehouseman			Private	e
9	be filed stal Hygi od other event, I	Be (17. Father's Name (First, Middle, Last)			18. Mother's Name (F		Sumame)	
yla	should t and Ment marked umatic	2	Willie Wood				Dowell	- Town Ctate 7	in Codo)
Maryland 2121	2 sh and is m		19a. Informant's Name/Relationship (Type	110	iling Address (Street at	Avenue		1 10WH, 312(6, 2)	ip code)
	1 and Health em 27 ther tr		Amy McDowell/wi:	ce car	position (Name of	ghtsMd.	20743 20c. Lo	ocation - City or 1	Town, Slate
ō	Pages nent of h int: If ite	- 0	1 Surial 2 ☐ Cremation 3 ☐ Re	moval from State cemetery, c.	rematory or other place	107.07		+1an	а ма
altimore,	t. Partmen		*4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee		ton Nation Nation 22. Name and Address			uitlan wards	
Bal	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat", or items 23a or 28a-f show any injury or other traumatic event, the Mudical Examinating must be notified at Once.		Anne son S		910 Silv				
	-4		23a. Part. Enter the disease, or complication	ations that caused the death. Do not e					Approximate Interval Between
	D iscontinuo		shock, or heart faiture. List only one Immediate Cause (Final	cause on each tine.		1 1 .			Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence of):	ac wi	hythmic			
	Examiner			husertersion	-				
	- 35	Jer	Sequentially list conditions if any, leading to immediate cause. Enter Underlying	Due or as a consequence of):				-	
	cuted nd ransit	Examiner	that initiated events c.	Reval FAI	UKL				
oʻ	e exercien ar		resulting in death) Last	Due to (or as a consequence of):					
8760,	death certificate be executed e attending physicien and nd for use as the buriat-transit	Physician/Medical	d.						
9	leath certifica attending ph I for use as th	Mec	IF FEMALE:	c. If yes, outcome of pregnancy				23d. Date of deli	in en
Box	ath c	lan/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetat death	3 □Ectopic pregnancy 5 □ Other (specify)			Month Month	Day Year
0	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	3 Other (specify)				
α.	law requires that the das been signed by the 2 should be detached		Part II. Dther significant conditions cont	ributing to death but not resulting in the	underlying cause give	en in Part t.	23e. Did tobacco	use contribute to	the cause of death?
Records,	uires sign	d by					1 ☐ Yes 2	No 3□ Pr	obably 4 Unknown
Sor	w requir been si should	lete					24a. Was an	24b. Were au	itopsy findings available
Re	و تـ و	Completed					autopsy performed? 1 ☐ Yes 2 2 No	death?	completion of cause of 2☑ No
Vital	ician: Th certificate rector, pag	CO	25. Was case referred to medical			26. Place of Death (
5	Physician: this certific ral director,	0 8	avaminar?	ospital: 1 ☐ Inpatient 2 ¥ ER/Outpa	tient 3 DOA Othe		5 Residence	6 □Other (Spe	cify)
of		l i	27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Tim-		at 28	d. Describe how intu	ry occurred	
ion	Attending I ir death. ector: Atter by the funer	atlo	1 Natural 5 Pending 2 Accident investigation	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Yes 2 □No			
Division	or Attendate death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28	f. Location (Street a. City or Town, State	nd Number or Ri e)	ural Route Number,
	To the Hospital or A within 24 hours after To the Funerel Direct completely filled in by) and	r stated
	Hospital 24 hours a Funerel l itely filled	edical	(Check only 2 Medical Exemin	ician: To the best of my knowledge, der: On the basis of examination and/o	eath occurred at the tim r investigation, in my op	ne, date and place, an pinion, death occurred	at the time, date an	d place, and due	e to the cause(s)
	To the I within 2. To the Complet	Med	29b. Signature and title of gertifier	and manner stated.	29c. License	e number	29d. Da	ate signed (Mont	th, Dey, Year)
	T X D		1/1/2/1	70.	Dh	8853	8	16/09	9
~	0		30. Name and address of person who cor	noleted cause of death (Item 23a) (Tv					
1	3		MALILIA F	AIR MD 3001	HUSPITAL	L DRIVE	OHEVSK	LY M	1 20785
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature)	
	Regist	rar	AIIG 1 1 2009 /2	we to part					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 David Jerome Murphy August 10:15 p M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Mallard Bay Care Center Dorchester Cambridge 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) Days Hours 1⊠ M 2□ F 214-42-9778 Feb. 3, 1945 Maryland 64 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2X No MD Caroline Federalsburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6406 Meadowlark Avenue USA 21632 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1∑Yes 2 □ No If Yes, Give Year or Dates: 1966–68 1 Never Married 2 Married white 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) owner/operator trucking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elmer Murphy Mary Marshall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dawn Y. Robinson daughter 8760 Black Dog Alley, Easton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Salisbury Crematory 8/10/09 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee -IC. 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 4ear ung Cancel Due to (or as a consequence of) Pailure Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Marical Examinating the nortified at once.

Baltimore, Maryland 21215-0036

and attending pl

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physiclan: The law requires that the death certificate be executed n 24 hours after death.

ne Funeral Director: Af
pletely filled in by the ful completely within 2

State Registrar 29b. Signature and title of certifier

31. Date filed (Month

ical Exa	resulting in death) Last	C								
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year							
<u>چ</u>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic obstructive lung discase 1 yes 2 no 3 protein									
Completed	24a. Was an autopsy performed? death? 1 □ Yes 2 □ No 1 □ Yes									
a)	25. Was case referred to medical	26. Place of Dec	ath (Check only one)							
To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H	Home 5 ☐ Residence 6 ☐ Other (Specify)							
	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		28d. Describe how injury occurred							
Certification	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
ical (nysician: To the best of my knowledge, death occurred at the time, date and plac niner: On the basis of examination and/or investigation, in my opinion, death occ								

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

			1 - State Registrar	Cei	rtificate of Death	•	Reg. No.2 () () 9	27221
	Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of De	ath Day Year	3. Time of Death
-	/Medi		Mary Anne Mudd			August	6, 2009	3:35P ^M
	Examir	ner	4a. Facility Name (If not institution, give street and number) 7375 Crain Hwy		4b. City, Town, or Location of Deatl La Plata	n	4c. County of Death Charle	
1	Funeral		7	yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Bir (Month, Da		place (State or Foreign ntry)
	Director		1 TH OKIT	35 Yrs.	Months Days Hours Min. Fel	(Month, Da	,1924 Vii	ntry) Cginia
	pu »		Usual Residence of Decedent	0% T				10d. Inside City Limits
	shov	5		c. City, Town or Lo				1 ☐ Yes 2 X No
	the M	rect	MD Charles 10e. Street and Number	La F	lata 10f. Zip Code		10g. Citizen of What Cour	
	3a or	Ö	7375 Crain Hwy		20646		USA	
	death	Funeral Director	11. Marital Status 12. Was Decedent Ever i	in U.S. 13.1	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No	- 14. Race - Ameri	
9000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Mcdical Evaluation is used to notified at once.	Completed by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ ↑ S 2 ☑ No If Yes, Give Year or Dates:		in res, specify Cubari, Mexican, Puero 1 □ Yes 2 ŽiNo <i>Specify:</i>	o Alcan, etc.)	1 ' '	etc. White
15-	"natu	ete	15. Decedent's Education (Specify only highest grade completed)	ı (Give	dent's Usual Occupation kind of work done during most of wor	king	16b. Kind of Business/In	dustry
12	withir ene. than		Elementary/Secondary (0-12) College (1-4or 5+)	ilre. I	DO NOT use retired) Homemaker		Home	
2	filed Hygi other ent,	Be C	17. Father's Name (First, Middle, Last)		-	ne (First, Middle,	Maiden Surname)	
<u>la</u> n	Aenta Aenta rked ric ev	To B	Carl R. Baldus,Sr.		Mary Mac	leline B	ray	
Maryland 21215-0036	nd 2 shoualth and N 27 is ma er trauma		19a. Informant's Name/Relationship (Type. Print) Richard Mudd/Son	19b. Mailir P.O.	ng Address (Street and Number or Ru Box 1113, La Pla	ural Route Numbe ata,MD	er, City or Town, State, Zij 20646	o Code)
Baltimore,	of He fitem		20a. Method of Disposition	Db. Place of Dispo	sition (Name of natory or other place)	Date	20c. Location - City or To	own, State
<u><u>Ĕ</u></u>	Page ment ant: It ury o		4 Donation 5 Other (Specify)	St. Mary'		7/2009	Charlotte H	Mall,MD
Salt	permit. Depart Import any Inj once.		21. Signature / Funeral Service Licensee MOO	1945 22	AREHART-ECHOLS FU	NERAL HO	DME,P.A.	
	= @ OI		Cave C. Chola		211 St. Mary's Av	a. La Pl	ata,MD 2064	
			23a. Part 1. Enter the disease, or complications that caused the d shock, or heart failure. List only one cause on each line. Immediate Cause (Final					Approximate Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	JA TU	Partection	noma		
7	Examiner		Due to (or as a con	sequence of):	partectic	V3 51	11cry mes	
	P =	ner	Sequentially list conditions, if any, leading to immediate cause. Eater Underlying	sequence of):				
	ecuter ind transi	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					
68760,	be exician a		resulting in death) Last Due to (or as a con	sequence of):				
87	icate physi the t	Medical	d					
O. Box (or Attending Physician: The law requires that the death certificate be executed bifred death. Differ death. After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burlai-transit.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 1 □ Unknown 23c. If yes, outcome of pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of deliv Month	ery Day Year
σ.	res that the de signed by the be detached		Part II. Other significant conditions contributing to death but not	resulting in the ur	nderlying cause given in Part I.	23e. Did to	obacco use contribute to t	he cause of death?
Vital Records,	w requires been sig should be	Completed by				1 🗆 🕻	Yes 22 No 3□ Pro	bably 4 🗌 Unknown
900	e law re has bee e 2 sho	plet				24a. Was	an 24b. Were auto	opsy findings available ompletion of cause of
Œ.	The late had page	mo.				autop perfo 1 □ Yes	osy prior to co death? 2 No 1 □ Yes	
/ita	ician: The certificate h ector, page	Be (25. Was case referred to medical examiner?		26. Place of Dea			
of	Physi this c	ဍ	4.7	2 ER/Outpatien		/ \	dence 6 Other (Speci	fy)
no	ding F h. After funera	tion	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28b. Time of Injury	28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe	now injury occurred	
Division	tal or Attendli s after death. al Director; A ed in by the fu	Certification:	2 Cuiside 6 Could not be	At home, farm, str		28f. Location (Street and Number or Rur	al Route Number.
Ö	al or safter	erti	4 Homicide determined 28e. Place of Injury - A building, etc. (Sp	ecify)		City or Tov	vn, Štate)	,
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the	Medical C	29a. Certifler (Check only one) A Certifying Physician: To the best of my 2 Medical Examiner: Of the basis of examiner manner stated.	knowledge, death mination and/or in	n occurred at the time, date and place vestigation, in my opinion, death occu	e, and due to the arred at the time,	cause(s) and manner as date and place, and due t	stated. o the cause(s)
	To the virthing of the composition of the compositi	Me	29b. Signature and little of certifier		29c. License number		29d. Date signed (Month,	Day, Year)
			12 Hou	0	D003342	.6	8-7-09	
(Dis		30. Name and address of person who completed cause of death (Print)			
7	010		B. Larry Jenkins; M.D. P.O.		La Plata,MD 206	46		
	Sta Registr		AUG 11 2009	D. A	all			

DHMH 17 Rev 1/2001

State Registrar

1 - For State Regis

To Be Completed by Funeral Director

Physician

/Medical

Examiner

Funeral

Examiner

Medical Certification: To Be Completed by Physician/Medical

AUG 1 2 2009

Please Type or Print in Black Inde			
State of Maryland / Depar State of Maryland / Depar State of Maryland / Depar	tment of Health and Mei ificate of Death	ntal Hygiene Reg. No. 🤈 🦳 🧎 (3 27222
1. Decedent's Name (First, Middle, Last)	2.	Date of Death Month Day Year	3. Time of Death 0145 A M
William Russell Matthews 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	08 // 7009 4c, County of Dea	
Peninsula Regional Medical Center	Salisbury	Wico	MICO
	If Under 1 Year I If Under 24 Hrs. 4. Months Days Hours Min.	Date of Birth (Month, Pay, Year) 9. Bir 3/10/1935	thplace (State or Foreign ountry)
Usual Residence of Decedent	Han	7 = 7 = 7	10d. Inside City Limits
10a. State 10b. County 10c. City, Town or Loca MD Worcester Berlin		10g. Citizen of What C	1 □Yes 2 No
100 Burley St.	10f. Zip Code 21811	USA	Surrity:
11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ▼ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼ Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y	as Decedent of Hispanic Origin? (Specif res, specify Cuban, Mexican, Puerto Ric □Yes 2☑No <i>Specify:</i>	an, etc.) Black, Whit	
(Specify only highest grade completed) (Give kill life. DC Elementary/Secondary (0-12) College (1-4or 5+)	nt's Usual Occupation nd of work done during most of working O NOT use retired) Crical Design Engir	16b. Kind of Business	
17. Father's Name (First, Middle, Last)		First, Middle, Malden Surname)	ilig
Russell Edmund Matthews	Mary Hargi	is Scott	
	Address (Street and Number or Rural F Burley St., Berlin		Zip Code)
20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		,	
21. Signature of Funeral Service Licensee 22.		rbage Funeral Hor	
23a. Par1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failtine. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Mutrue Strem a Condition Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): c. Actual Stremas Amount of the death. Do not enter shock, or heart failtine. Disease or injury that initiated events resulting in death) Last	N FAILURE	TERLY BYPASS	Approximate Interval Between Onset and Death (DAY 4.0A45
	Ectopic pregnancy Other (specify)	23d. Date of d	olivery Day Year
Part II. Other significant conditions contributing to death but not resulting in the und	erlying cause given in Part I.	23e. Did tobacco use contribute	
RENAL FAILURE WITH DRYSIS PRE-OP CONCESTAR HEALT FAILURE		24a. Was an autopsy prior to death?	Probably 4 Vunknown utopsy findings available completion of cause of
25. Was case referred to medical examiner?	26. Place of Death (0		
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 2 Note of Death 1 Inpatient 2 ER/Outpatient 2 Saa. Date of Injury (Month, Day, Year) 2 Sab. Time of Injury 3 Suicide 4 Homicide 2 Sab. Place of Injury - At home, farm, street building, etc. (Specify)	28c. Injury at Work? M 1 Yes 2 No	b 5 Residence 6 Other (Sp. d. Describe how injury occurred f. Location (Street and Number or F. City or Town, State)	
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or invegand manner stated.	occurred at the time, date and place, an sstigation, in my opinion, death occurred	d due to the cause(s) and manner at the time, date and place, and du	as stated. ue to the cause(s)
29b. Signature and title of certifier	29c. License number	29d. Date signed (Mor	
30. Name and address of person who completed cause of death (Item 23a) (Type, Programs Todd 100 E. Cernil St. Salis 131. Date filed (Month, Day, Year) 32. Registrar's Signature	rint)		

DHMH 17 Rev 1/2001

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			For State Registrar	State of	f Marylan		rtment of H <i>tificate of L</i>			giene Reg. No. 🦳	000	07000
		-	1. Decedent's Name (First, Midd					-	2. Date of Dea	ath	Year	3. Time of Death
P	hysicia Medic		Georgeanna Me	euth Munde.	11				August	Day 7 . 20	Year 09	11:25 A M
**	/wedic Examin		4a. Facility Name (If not institution	n, give street and nur	mber)			Location of Death			inty of Death	
a di			4940 Sentinel	Drive Apt			Bethesd		_		gomery	
	uneral rector		5. Social Security Number 578–40–3003	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs. I	ast birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month Da Dec 11,	1928	l Cour	place (State or Foreign htry) ucky
Pu	2		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Loc	eation					0d. Inside City Limits
aryla	shov	٦				hesda	ation					1√⊡Yes 2 □ No
the N	28a-f	rect	10e. Street and Number	gomery	Det	nesua	10f. Zip Code			10g. Citizen	of What Cour	21
with	3a or	Funeral Director	4940 Sentinel	Dr, #306			20816				d Stat	
leath	ms 2;	nera	11. Marital Status	12. Was Dece	edent Ever in U.S	S. 13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No	- 14.	Race - Americ	
G Z IZ 13-0030 filed within 72 hours after death with the Maryland Hygiene.	Important; if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Medical Examination must be notified at once.	by Fur	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	I If Yes Giv	ve		Yes, specify Cuba	specify:	Hican, etc.)		Black, White, _{ecify:} Whit	
3-UL	atura	ted	15. Deceder	nt's Education		16a. Deced	ent's Usual Occup	ation		16b. Kind o	of Business/in	dustry
6 . e.	an "n Modi	Completed	(Specify only higher Elementary/Secondary (0-12)	college (1	I-4or 5+)		kind of work done of NOT use retired	during most of world f)	king			
A L	th a	Son		5+`		Teac	her				ation	
and d be file ental Hy	d oth event	Be	17. Father's Name (First, Middle, George William					18. Mother's Nam	he (First, Middle, ${f 81}$ iss ${f S1}$		name)	
y id	narke	၉				T					01-1- 7	- 0 - 4 -)
Vial 12 sh th and	7 is n traun		19a. Informant's Name/Relations Kenneth Munde		.a		g Address (Street					
t and Healt	em 2 ther		20a. Method of Disposition	zii/ nusban			Sentine Sition (Name of patory or other place		Date		on - City or To	
ages ant of	t: If It y or c		1 ☐ Burial 2 🏝 Cremation		State			1	10 2000		01	1 774
Daltino	ortan injur		4 ☐ Donation 5 ☐ Other (5		Nat	ional 22	Crematory . Name and Addres	Facility Too	10,2009	Fall	s Chur	ch, VA
Dep Dep	any		>Ullians	R B	2011							DC 20016
			23a. Part 1. Enter the disease, o shock, or heart failure. Lis	r complications that	aused the death	n. Do not ente						Approximate Interval Between
Phys	sician	9	Immediate Cause (Final disease or condition				ve Pulmor					Onset and Death Years
/Me	edical		resulting in death)	u.	(or as a consequ		ve rumoi	lary Disc	.230			rears
Exa	miner		Sequentially list conditions,	b								
pe	ti s	Examiner	day, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Stra to r	(or as a consequ	isinge offic						
xecut	and I-tran	xar	that initiated events resulting in death) Last	c	(or as a consequ	uence of):						
orou, icate be executed	physician and s the burial-transit	ᇛ			(,						
00/	g phys	edical		a				3-				
ath cert	anding use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna		15			23d	. Date of deliv	ery
death	e atte	icia	in the past 12 months? 1 □Yes 2X No		birth 2 Teta nant at time of d		Ectopic pregnanc Other (specify) _				Month	Day Year
at the d	by th	hys	9 🗌 Unknown						1			
OI VITAL RECORDS, P.O. BOX of Physician: The law requires that the death certif	been signed by the attending should be detached for use as	by	Part II. Other significant condit	ions contributing to de	eath but not resu	ulting in the ur	nderlying cause giv	en in Part I.			contribute to No 3 ☐ Pro	the cause of death? bably 4 Unknown
<u>ခ</u>	After this certificate has been s funeral director, page 2 should	Completed							24a. Was		4b. Were aut	opsy findings available
The Fa	te has age 2 s	шо					, 2, 1111		auto perfo 1 □ Ye s	psy ormed? 2 ☑No	death?	ompletion of cause of
VITCH Iclan: T	certificate rector, pag	Be C	25. Was case referred to medica	al				26. Place of Dea			10.00	2 110
r v	this ce al direc	To B	examiner? 1 ☐ Yes 2 🎇 No	Hospital: 1 □	Inpatient 2	ER/Outpatien	t 3 DOA Oth	er: 4 🗆 Nursing H	lome 5 🖁 Res	idence 6	Other (Spec	ify)
	After th funeral	ü	27. Manner of Death 1 ☐ Natural 5 ☐ Pendi	28a. Date (Mon	of Injury hth, Day, Year)	28b. Time of Injury	28c. Injur Wor	y at k?	28d. Describe	how injury o	ccurred	
VISION Attending r death.	or: A	cati		tigation				Yes 2 □No				
LIVISION I or Attending after death.	Director: d in by the	Certification:		mined 28e. Place buildi	of Injury - At ho ing, etc. <i>(Specif</i>	ome, farm, stre	eet, factory, office			Street and N wn, State)	lumber or Hui	al Route Number,
DIVISIO To the Hospital or Attendi within 24 hours after death.	To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certify (Check only one) 2 Medica	ing Physician: To the ii Examiner: On the b and man	e best of my kno pasis of examina oner stated.	wledge, death	n occurred at the tivestigation, in my o	me, date and place	e, and due to the urred at the time	cause(s) ar , date and pla	nd manner as ace, and due	stated. to the cause(s)
Fo the vithin	Fo the	Me	29b. Signature and title of certific		1 1		29c. Licens	e number		29d. Date s	igned (Month	, Day, Year)
6	- 0		> Much	ad 1/2	hode	1	M71	1501		August	7,200	9
, 4			30. Name and address of person Michael Grady,	who completed cause	se of death (Iten	dral A	Print)	#114W Wa	shingto	n DC 2	0016	
	Sta		31. Date filed (Month, Day, Year	r) 32/F	Registrar's Signa							
	Registr	ar	AUG 10	7009 Ze	was fo	1. 149.00						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 7,2009 1:20 РМ Whitson Jarvis Moody 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Montgomery Brighton Gardens at Friendship Heights Chevy Chase If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day) 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) 1 X M 2 □ F Days Hours 149-22-4663 04-23-1928 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location X Yes 2 □ No DC Washington DC 10e. Street and Number 10g. Citizen of What Country? 1314 35th St., N.W. 20007 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Banker Banking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dwight L. Moody Ruth Jarvis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Moody/Wife 1314 35th St., N.W. Washington DC 20007 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Falls Church, VA National Crematory 8-10-09 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons, INC 21. Signature of Funeral Service License 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin... Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pneumonia 2 days Due to (or as a consequence of): Parkinson's Disease Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) delivery Day Year e to the cause of death? Probably 4 Unknown

Physician /Medical **Examiner**

permit. Pages
Department of
Important: If it
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once.

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Evar ingr must be notified at

Completed by Funeral Director

Be

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Examiner

Be Completed by Physician/Medical

Certification: To

Medical

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene, int: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

spital or Attending Physician: The law requires that the death certificate be executed ours after death.

earl Director: After this certificate has been signed by the attending physician and filled in by the furneral director, page 2 should be detached for use as the burlat-transit

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic preg 5 ☐ Other (special			23d. Date of delivery Month Day	Year
Part II. Other significant conditions	contributing to death but not resulting in t	he underlying caus	e given in Part I.		use contribute to the cau	se of death?
				24a. Was an autopsy performed? 1 □Yes 2 ☑No	24b. Were autopsy fir prior to completi death?	on of cause of
25. Was case referred to medical			26. Place of Dea	th (Check only one)		. 1
examiner? 1 ☐ Yes 2 ☐ X No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp	oatient 3 DOA	Other: 4 Nursing H	ome 5 Residence	ASSIS 6 Other (Specify)	ted Liv
27. Manner of Death	28a. Date of Injury 28b. Tir	me of 28c.	Injury at	28d. Describe how inju	ry occurred	

Assisted Living 1X Natural (Month, Day, Year) Work? 5 Pending 1 □ Yes 2 □ No 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

D34590

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29b. Signature and Itle of certifier

31. Date filed (Month, Day, Year)

29c. License number 29d. Date signed (Month, Day, Year)

August 8,2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Roy Fried, M.D. 6430 Rockledge Drive, #470 Bethesda, MD 20817

Registrar

To the Hospital or within 24 hours af To the Funeral D

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day **Physician** 8:15 Caro1 Ε. August 2009 A^M Newton /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert Calvert Memorial Hospital Prince Frederick 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 😿 F 08-09-1938 70 D.C. Wash.. Director 408-68-9650 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and the flam and the modified at uny or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 □Yes 2 No Director MD Anne Arundel Lothian 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 164 B Street 20711 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married 1 □ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 bookkeeper Flooring Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ျှ Richard Emelio Josephine 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If Item 27 Is any injury or other trau once. Robert J. Newton, spouse 164 B Street, Lothian, MD 20711 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 08-07-09 Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. William 8325 Mt. Harmony Lane, Owings, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months. 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has certificate has rector, page 2 autopsy performed Colorrar 2 □ N0 2 No 1 ☐ Yes 25. Was case referred to medical examiner? al director, Be 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1√0 After this c funeral dire Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Injury (Month, Day Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No s after death. 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C 1 🗹 certifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 5KW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mukesh Mathur, MD ,110 Hospital Rd., Suite 305, Prince Frederick, MD 20678

Registrar

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** elia Japenfus /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Dehals South Edsewater If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 11/08/1911 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🔽 F 97 195-07-8522 Director Usual Residence of Decedent the Maryland 10b. County 10c. City. Town or Location 10a. State ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Maryland Anne Arundel Edgewater Director 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item. any injury or other trainmant. 21037 508 Overhill Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. ξ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lisetta Schreck Frederick W. Papenfus 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 508 Overhill Drive, Edgewater, Maryland 21037 19a. Informant's Name/Relationship (Type. Print) Dawn L. Kilheffer/Niece 20b. Place of Disposition (Name of cemetery, crematory or other place)
Kalas Crematory Date 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 08/09/2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Funeral Service License 2973 Solomons Island Road, Edgewater, MD 21037 Part1. For the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should, or heart failure. List only one cause on each line. 234 Part1. Imme late Cause (Final disease or condition resulting in death) vsician meestive **l**ledical Due to (or as a concequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Errer Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ Completed 24a. Was an the Hospital or Attending Physician: nin 24 hours after death. the Funeral Director: After this certified 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide ithin 24 hours a 29a. Certifier VC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 1)0053705 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAWH 14300 32. Registrar's Signature 31. Date filed (Month, Day, Year)

9. Birthplace (State or Foreign Pennsylvania 10d. Inside City Limits 1 ☐ Yes 2 No 10g. Citizen of What Country? United States 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Federal Government 20c. Location - City or Town, State Edgewater, Maryland Approximate Interval Between Onset and Death 23d Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No was autopsy performed? Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year)

3. Time of Death

5.15P M

Mudel

Day

8Th

Year

2005

4c. County of Death

Anne

Registrar DHMH 17 Rev 1/2001

State

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Regis DHMH 17 Rev 1/2001

	For State Registrar		epartment of l Certificate of		a wentarri	Reg. No	COMM	27227
ian	1. Decedent's Nam <i>e (First, Middle, L</i> as <i>t)</i> Magdelena S. Pantelides				2. Date of D Month August		^y 2009	3. Time of Death 08:48 PM
ical ner	4a. Facility Name (If not institution, give street and number Anne Arundel Medical Cente	,	4b. City, Town, o	or Location of De	eath	40	County of Death	
	144-18-0006 1□M2XF	ge (In yrs. last birthd 91 Yrs	Months Davs	If Under 24 F Hours M	8. Date of B in. 07/16/	rth 1918	9. Birti New	nplace (State or Foreign untry) York
_	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or				_		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
ctc	Maryland Anne Arundel		Annapolis					A
al Director	10e. Street and Number 1612 Margaret Avenue		10f. Zip Code	401		_	itizen of What Co Jnited St	
by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Deceden Armed Forces 1 Yes 2 Western Sive Year or Dates	? No	13. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ☐ No	Hispanic Orlgin? an, Mexican, Pu Specify:	(Specify Yes or N erto Rican, etc.)	0-	14. Race - Ame Black, White Specify: W	
Completed by	15. Decedent's Education (Specify only highest grade completed)	(G	ecedent's Usual Occu Give kind of work done fe. DO NOT use retire	pation during most of a	vorking	16b. F	Kind of Business/	industry
Som	Elementary/Secondary (0-12) College (1-4or	D+1 I	omemaker				Home	
To Be (17. Father's Name (First, Middle, Last) Savvas Comsudis				_{Name (First, Middle} asia Xant		n Surname)	
=	19a. Informant's Name/Relationship (Type. Print)	19b. M	lailing Address (Stree	and Number or	Rural Route Num	ber, City	or Town, State, 2	?ip Code)
	John Pantelides/Son		9 Virginia	Street				
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery,	isposition (Name of crematory or other pla rios Greek C	emetery O	-	Anna	apolis, Mar	ryland
	21. Signature of Funeral Service Licenses		22. Name and Addr 2973 Solom		_			
al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	s a consequence of):	Preus	Hour	ilune al E a	ffe	is i On	
Completed by Physician/Medical		e of pregnancy 2 □ Fetal death at time of death	3 ☐ Ectopic pregnan 5 ☐ Other (specify)	су			23d. Date of del Month	ivery Day Year
oy Pt	Part II. Other significant conditions contributing to death		N	ven in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
ted	Cenosic Encepha	elepara	ey 		_ 1□	Yes 2	2 □ No 3 □ Pr	obably 4 🗹 Unknown
Somple	Hyponationia	ation			— 24a. Wa aut per 1 □Yes	opsy formed?	「	topsy findings available completion of cause of 2 No
Be (25. Was case referred to medical examiner?				Death (Check only	one)		
2	1 Yes 2 No Hospital: 1 1 Inpa	ient 2 ER/Outpa	atient 3 1 DOA		g Home 5 ☐ Re:			cify)
ation	27. Manner of Death T Natural 5 Pending (Month, Death 28a. Date of In (Month, Death 27a 27	ay, Year)	iry Wo	ryai rk?]Yes 2 □ No	280. Describe	now inju	ary occurred	
ertific	3 Suicide 6 Could not be determined 28e. Place of In building, 6	ijury - At home, farm tc. <i>(Specify)</i>	, street, factory, office		28f. Location City or To	(Street a	und Number or Ru te)	ıral Route Number,
Medical Certification: To	29a. Certifier (Check only one) **Medical Examiner: On the basis and manner services.**	of examination and/o	death occurred at the or investigation, in my	ime, date and p opinion, death o	lace, and due to the occurred at the time	e cause(e, date ar	(s) and manner as nd place, and due	s stated. to the cause(s)
Me	29b. Signature and title of certifier Hadill Josephik	er3late	29c. Licen		/	_	ate signed (Mont	
	30. Name a address of person who completed cause of Judy Joseph-Herbert	death Item 23a (Ty	pe, Print)	AMC	100 1 M Anna	DOT!	ical the	21401
ate rar		trar's Signature				/ ! !	/	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 06 **Physician** 2009 August Anthony James Petriccione /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 10/02/1936 120-26-5225 72 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show If item 27 is marked other than "natural", or items 23a or 28a-f shot or other traumatic event, the "housal Examiner must be nullified at Director Maryland | Anne Arundel Crownsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 852 Birch Trail 21032 United States Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 □ No If Yes, Give Year or Dates: Vietnam Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Statistician Federal Government Department of Health and Mental Hygie Important: If item 27 is marked other i any injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Janus S. Petriccione Agatha C. Acampora ပ 19a. Informant's Name/Relationship (Type. Print)
Dorothy Petriccione/Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 852 Birch Trail, Crownsville, Maryland 21032 20b. Place of Disposition (Name of cemetery crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Our Lady of the Fields Cent. 08/10/2009 Millersville, Maryland 5 Other (Specify) 4 ☐ Donation 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 23a. P. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or in art failure. List only one cause on each line. Immediate Cause (Final Physician Corona disease or condition resulting in death) /Medical Examiner Examiner Division of Vital Records, P.O. Box 68760, Physician/Medical

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours a

þ

Completed

Be (

Certification: To

Medical

Sequentially list conditions, f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. if yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I. 23e.	Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Atrial ari	and ant distance to a l	Was an autopsy findings available prior to completion of cause of death? Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical	26. Place of Death (Check	only one)
examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Residence 6 Other (Specify)
27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year) Injury Work?	cribe how injury occurred
3 Suicide 6 Could not to determined	a 28e, Place of Injury - At nome, farm, street, factory, office 28f, Loca	tion (Street and Number or Rural Route Number, or Town, State)
	Physician: To the best of my knowledge, death occurred at the time, date and place, and due aminer: On the basis of examination and/or investigation, in my opinion, death occurred at the and manner stated.	
29b. Signature and title of certifier	Berey MO 2957/	29d. Date signed (Mgnth, Day, Year) 08/07/2009
80. Name and address of person who	completed was of death (Item 23a) (Type, Print) PZ MD 2225E Oefense Hwy	Crofton, MD 21114
31 Date filed (Month Day Year)	32 Pagistrar's Signature.	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

10d. Inside City Limits

Approximate Interval Between Onset and Death

years

1 ☐ Yes 2 XNo

05:27 A™

State Registrar

Decedent 10b. County Montgomen mber tlake Term	ry race, #1404 The street and number) ace, #1404 The street and number) 7. Age 8. Age 8. Age 9. Age 9	20b. Pice Jud	16a. Deced (Give I life. L Bookk 19b. Mailin 28390 ace of Disposemetery, crem Mee	Bethes If Under 19 Months D cation 10f. Zip Co 20817 Was Decedent If Yes, specify 1 Yes 2 dent's Usual O kind of work of DO NOT use in ceeper ag Address (S: D Villa sition (Name ematory or othe em. Gdm C. li RO ter the mode of	wn, or Locardan Argent If Pays Francisco In Cuban, No. S. Docupation done during retired. 18 R.	B. Mother's Nan Rose Tr H Number or Ru Lake Wa 08/00 00 f Facille, M	pecify Yes or No Rican, etc.) king me (First, Middliband ural Route Num y East Date 6/2009 zansky— le Pike	Day 4c. C Mo 10g. Citiz USA 16b. Kin Reta e, Maiden S ber, City or On, M 20c. Loc Olne	een of What Cour 4. Race - Americ Black, White, Specify: 11 Surname) 7 Town, State, Zig D 21601 cation - City or Toy, MD	place (State or Foreintry) igan 10d. Inside City Limi 11 Yes 2 In Intry? Ican Indian, etc. Inite Industry
Lake Terral	ry race, #1404 The state of t	20b. Pice Jud	Town or Locales de San	Bethes If Under 19 Months D cation 10f. Zip Co 20817 Was Decedent If Yes, specify 1 Yes 2 dent's Usual O kind of work of DO NOT use in ceeper ag Address (S: D Villa sition (Name ematory or othe em. Gdm C. li RO ter the mode of	sda fear If hays H and If hays H	anic Origin? (S Mexican, Puerte Specify: an Mother's Nan Rose Tr d Number or Ru Lake Wa 08/00 f Facility an Rockvil	pecify Yes or No Rican, etc.) king me (First, Middliband ural Route Num y East Date 6/2009 zansky— le Pike	10g. Citiz USA o- 1 16b. Kin Reta e, Maiden S ber, City or on, M 20c. Loc	9. Birthy Mich 9. Birthy Mich 1 ten of What Cour 4. Race - Americ Black, White, Specify: WI d of Business/In il Furname) Town, State, Zip D 21601 cation - City or To y, MD	place (State or Foreintry) 1 gan 1 tod. Inside City Limi 1 Yes 2 N ntry? Ican Indian, etc. nite Industry
mber tlake Teri ied 2 Married 4 Divorced 15. Decedent's Educity only highest grade ondary (0-12) (First, Middle, Last) andick ame/Relationship (Ty, Conner-Son position Cremation 3 R 5 Other (Specify) eral Service License of the disease, or compliant failure. List only or (Final on the service content of the conner	race, #140 12. Was Decedent E Armed Forces? 1	10c. City, Beth 04 Ever in U.S. Io 10c. City, Beth 014 Ever in U.S. Io 10c. City, Beth 014 Ever in U.S. Io 10c. City, Beth 014 Ever in U.S. Io 10c. City, Beth	Town or Locales and Associated As	10f. Zip Co 20817 Was Decedent If Yes, specify 1 □ Yes 2 ☑ dent's Usual O kind of work of DO NOT use in Keeper Mace and A Common C	To this page 1 to of Hispan No S Decupation done during retired) 18 R Street and age L of pripace) 18 . Address of R DCkvi	Specify: S. Mother's Nan Rose Tr S. Mumber or Ru Lake Wa 08/0 of Facility an Rockvil	pecify Yes or No Rican, etc.) king ne (First, Middliband iband y East Date 6/2009 zansky— Le Pike	10g. Citiz USA o 16b. Kin Reta e, Maiden S ber, City or on, M 20c. Loc Olne	4. Race - Americ Black, White, Specify: What of Business/In 11 Surname) Town, State, Zig D 21601 cation - City or Toy, MD	10d. Inside City Limi 1 Yes 2 N Intry? Ican Indian, etc. In 1 te Industry Ip Code)
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ied 2 Married 4 Divorced 15. Decedent's Educity only highest grade indary (0-12) (First, Middle, Last) andick ame/Relationship (Ty, cosner—Son position Cremation 3 A S 5 Other (Specify) eral Service License art failure. List only or (Final	Armed Forces? 1 Yes 2 New Year or Dates: cation e completed) College (1-4or 5+ I Demoval from State ee MC ications that caused ne cause on each line Uremia a. Uremia	20b. Place Jud 01255 the death.ee.	16a. Deced (Give I life. L. E. Bookk 19b. Mailin 28390 ace of Disparentery, cremetery, cremetery, cremeter Chrone	dent's Usual O kind of work of DO NOT use in Keeper and Address (S. D. Villa institution (Name a matory or other and the control of the cont	Decupation of proplets of the place of the p	Specify: S. Mother's Nan Rose Tr S. Mumber or Ru Lake Wa 08/0 of Facility an Rockvil	ne (First, Middliband ural Route Num y East Date 6/2009 zansky—	Reta Reta ber, City or On, M 20c. Loc Olne	Black, White, Specify: What of Business/In 11 Surname) Town, State, Zip D 21601 cation - City or Toy, MD	etc. nite ndustry
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anditions,			ence of):	nic Kid				arrest,		Interval Between Onset and Death Years
enying injury s Last	Due to or as a Due to or as a									
nt pregnant t months? ⊠No	23c. If yes, outcome of 1 Live birth 2 Pregnant at 9 Unknown	2 🗌 Fetal	death 3□	□ Ectopic preg □ Other <i>(sp</i> ec				2	23d. Date of deliv	very Day Year
ficant conditions cor	ntributing to death bu	ut not resu	ilting in the ur	nderlying caus	se given i	in Part I.				the cause of death?
rred to medical						O. Disse of De	aut per 1 □ Yes	opsy formed? 2 K No	prior to co	topsy findings availa completion of cause 2 □No
No F th 5 ☐ Pending	28a. Date of Injur	ry			Other: c. Injury at Work?	4 ☐ Nursing H	lome 5X Re	sidence 6		:ify)
6 Could not be determined	1		/			data and place	City or T	own, State,)	
2 ☐ Medical Exami	iner. On the basis of	f examinat	tion and/or in	nvestigation, in	n my opin License n	nion, death occ	urred at the tim	e, date and 29d. Dat	l place, and due te signed (Month	to the cause(s) n, Day, Year)
	th 5 Pending investigation 6 Could not be determined	th S Pending investigation Could not be determined Certifying Physicians To the best 2 Medical Examiner On the basis of and manner starting of the certifier	th S Pending investigation Could not be determined Certifying Physician To the basis of examinar and manner stated.	Hospital: 1 Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day, Year) 5 Pending investigation 6 Could not be determined 28e. Place of Injury - At home, farm, strength building, etc. (Specify) 1 Certifying Physician To the best of my knowledge, dear 2 Medical Examiner On the basis of examination and/or in and manner stated.	The Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	The Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: th 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Work? 1 Year 28b. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time 2 Medical Examiner On the basis of examination and/or investigation, in my opin and manner stated.	The Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Figure 1 North State of Injury 2 Sea. Date of Injury 2 Sea. Date of Injury 3 North State of Injury 4 Nursing Figure 3 DOA Other: 4 Nursing Figure 3 North State of Injury 4 North State of Injury 5 North State of Injury 6 North State of Injury 7 North State of Injury 8 North State of Injury 9 North State of Injury 1 North State of Injury 2 North State of Injury 3 North State of Injury 4 North State of Injury 5 North State of Injury 6 North State of Injury 7 North State of Injury 8 North Sta	24a. Wa autopeter 1 Yes 26. Place of Death (Check only peter 1 Yes 1 Yes 27. Pending investigation 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28c. Place of Injury - At home, farm, street, factory, office 28c. Location 28c. Place of Injury - At home, farm, street, factory, office 28c. Location 28c. Place of Injury - At home, farm, street, factory, office 28c. Location 28c. Place of Injury - At home, farm, street, factory, office 28c. Location 28c. Place of Injury - At home, farm, street, factory, office 28c. Location 28c. Place of Injury - At home, farm, street, factory, office 28c. Location 28c. Place of Injury - At home, farm, street, factory, office 28c. Location 28c. Place of Injury - At home, farm, street, factory, office 28c. Location 28c. Place of Injury - At home, farm, street, factory, office 28c. Location 28c. Place of Injury - At home, farm, street, factory, office 28c. Location 28c. Place of Injury - At home, farm, street, factory, office 28c. Location 28c. Place of Injury - At home, farm, street, factory, office 28c. Location 28c. Place of Injury - At home, farm, street, factory, office 28c. Location 28c. Place of Injury - At home, farm, street, factory, office 28c. Place of Injury at 28c. Place of Injury at 28c. Injury	24a. Was an autopsy performed? 1	rred to medical No

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene 23aPt1, 28a-f per me, 2895, 09/02/09dhb Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2009 **Physician** August 9, Herbert Bernard Rush 12:36 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 41941 Newman Way St. Mary's Leonardtown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 07/23/1935 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 74 578-44-3900 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 21 No Director St. Mary's Leonardtown 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 41941 Newman Way 20650 U.S.A. 1 and 2 should be filed within 72 hours after death v Health and Mental Hygiene. em 27 is marked other than "natural", or Items 23s Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No à Specify: 3 Widowed 4 Divorced white Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 mechanic charter company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Τ., Rush Mildred Spalding 5 contracts traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20732 19a. Informant's Name/Relationship (Type. Print) Department of Health Important: If item 27 any Injury or other tr Michael W. Willis, son 4481 Christianna Parran Rd., Chesapeake Beach, MD Pages 1 ament of He 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ▼ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 □Removal from State Metropolitan Crematory 08/13/2009 Alexandria, VA 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Sign to of Funeral Service License 8325 Mt. Harmony Lane, Owings, MD ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e. List only one cause on each line. **Gunsho Wound of Head** 23a. Part1. Enter the disc shock, or heart failu Approximate Interval Between Onset and Death Immediate Cause (Fin disease or condition resulting in death) **Physician** /Medical Due to (or as a consequer Examiner Sequentially list conditions, and the list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine certificate be executed Due to (or as a consequence of): Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month in the past 12 months? Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 1 Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? 1XYes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 9 28a. Date of Injury (Month. Day Year) in by the funeral 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending P within 24 hours after death.

To the Funeral Director: After it Division 5 Pending investigation 1 Natural Found: 7:00a M 08/09/2009 Subject shot self 1 ☐ Yes 2 X No 2 Accident 6 □ Could not be 3 Suicide 28f. Locetion (Street and Number or Rural Route Number, City or Town, State 41941 Newman Way Leonardtown, MD 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Shed Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and itle of certifier 29c. License number 29d. Date signed (Month, Day, Year) August 10, 2009

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State Registrar AUG 12 2009 Server B. Lank

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

II,

William D. Boyd,

31. Date filed (Month, Day, Year)

, 25365 Point Lookout Road, Leonardtown, Maryland 20650

State Registrar DHMH 17 Rev 1/2001

5H-2

1471160-

AUG 13

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W1250M

32. Registrar's Signature

ANTIETM

MD

HUG GRS POWN

	State of Maryland / Department of Hear State 1 - State Certificate of De	
Physician	Decedent's Name (First, Middle, Last) Joshua Rivlin	2. Date of Death Nonth Day Year August 07. 2009 2:50 P M
/Medical Examiner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Loc	August 07, 2009 [2:30
Funeral Director		Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/19/1940 Palestine
D	Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location	10d. Inside City Limits
faryla f shov		1 M Yes 2 □ No
ith the Mar or 28a-f st be nutthed	MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
th with	13860 Turnmore Road 20906	U.S.A.
72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Exant net coust be notified at the country of the country o	1 ☐ Never Married 2 📉 Married 1 📉 Yes 2 ☐ No	nic Origin? (Specify Yes or No- fexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: Specify:
ed within 72 hours ygiene. ner than "natural" t, I'n Medical Ex	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done durin	White 16b. Kind of Business/Industry
≢ <u> </u>	Liementary/Secondary (0-12) College (1-4or 5+) Computer Programe	
z should be and Mental is marked o raumatic ever		Devora Hilsenrath Number or Rural Route Number, City or Town, State, Zip Code)
l and 2 s Health ar tem 27 is other trau		Rd. Silver Spring MD 20906
ges 1 and 2 should It of Health and Mer If Item 27 is marke or other traumatic	20a. Method of Disposition 1 Burial 2 Defermation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State
permit. Pages 1 Department of I Important: If ite any Injury or ot	4□Donation 5□Other (Specify) National Crematory	8-11-2009 Falls Church VA
and be	21. Signature of Funeral Service Trensee Mo 1477 22. Name and Address of Danzansky-Go 1170 Rockyi	Facility oldberg Memorial Chapels Inc. lle Pike Rockville, MD 20852
Physician /Medical	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, so shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. Neutropenic Infection a. Neutropenic Infection	
Within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certification: To Be Completed by Physician/Medical Examiner	Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Chronic Lymphocytis Leukemia of the cause	8 years
d by the attending pletached for use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknown Unknown 23c. If yes, outcome of pregnancy 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 1 Unknown 1 Unknown 23c. If yes, outcome of pregnancy 3 Ectopic pregnancy 5 Other (specify) 1 Unknown 1 Unknown	23d. Date of delivery Month Day Year
n signed by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Thrombocytopenia	Part I. 23e. Did tobacco use contribute to the cause of death? 1
s certificate has been s lirector, page 2 should	Anemia	24a. Was an autopsy performed? 1 □ Yes 2 ▼ No 24b. Were autopsy findings availab prior to completion of cause o death? 1 □ Yes 2 ▼ No
s certific lirector,	examiner/	. Place of Death (Check only one)
ath. r: After this e funeral dir	27. Manner of Death 11☑ Natural 5 ☐ Pending 128a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work?	4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 2 ☐ No
rs after death. el Director: After led in by the funer. Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
thin 24 hours the Funere ompletely fille	29a. Certifier (Check only one) 1X Certifying Physician: To the best of my knowledge, death occurred at the time, of the desired physician in the	date and place, and due to the cause(s) and manner as stated. on, death occurred at the time, date and place, and due to the cause(s)
To the company of the	29b. Signature and title of certifier 29c. License nur	mber 29d. Date signed (Month, Day, Year)
10	30. If me and address of person who completed cause of death (Item 23a) (Type, Print)	August 8, 2009
State Registrar	Linda M Burrell, MD 2730 University Blvd. # 400 31. Date filed (Month, Day, Year) AUG 11 2009 Linda M Burrell, MD 2730 University Blvd. # 400 33. Registrar's Signature	Wheaton MD 20902

DHMH 17 Rev 1/2001

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marical Examiner must be notified any once. Baltimore, Maryland 21215-0036

1 - For State Registrar

10a. State

Physician

/Medical

Examiner

Funeral

Director

Physician /Medical Examiner

g physician and as the burial-trans attending pl been signed by the should be detached To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s

> State Registrar

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

WV 10e. Street and Nu 349 S. 11. Marital Status 1 Never Marital Widowed (Spe	Miner	al	Ke	yser						1 X Yes 2 □ N
10e. Street and Nu	ımber				Zip Code			10g. Citi;	zen of What	Country?
349 S	. Main St	reet			2672	26			US	A
11. Marital Status		12. Was Decedent Eve	r in U.S.	13. Was Dec	edent of I	Hispanic Origin? (an, Mexican, Pue	Specify Yes or	No-		merican Indian,
1 ☐ Never Mari	ried 2 Married	Armed Forces? 1 XYes 2 ☐ No					no nican, etc.)	- 1	Black, W	nite, etc.
3 ☐ Widowed	4 X Divorced	If Yes, Give Year or Dates: 19	74-78	1 LI Yes	2 X No	Specify:			Specify:	White
(600	15. Decedent's Ed	ducation	16a. [Decedent's Us	sual Occup	ation during most of we	rkina	16b. Kir	nd of Busine	ss/Industry
Elementary/Sec		College (1-4or 5+)	-	life. DO NOT	use retire	d)	orking .	P1a	stic	Bag
12				Machin	е Оре	erator		Mar	ufact	uring
17. Father's Name	(First, Middle, Last,)				18. Mother's Na	ame (First, Mid	dle, Maiden	Surname)	
John H.	. Rice, J	r.				Judit	h Lynn	Webb		
19a. Informant's N	lame/Relationship (Type. Print)	19b. i	Mailing Addre	ss (Street	and Number or F	Rural Route Nu	mber, City or	r Town, State	e, Zip Code)
Brenda I	K. Rice/S	ister-in-law	,	P.O. B	ox 3	l4 Barte	on, MD	21521		
20a. Method of Dis	sposition	:	20b. Place of [Disposition (A	lame of	(0)	Date	1	cation - City	or Town, State
	Cremation 3 ☐ 5 ☐ Other (Specif	Removal from State		crematory o		i i	Aug. 18		nh a m I a	md WI
1	ungegał Service Liger		ine cui			ematory ess of Facility	2009 Smith Fu			ind, MD
1	Bullet	Thutth	-			in Stre				726
23a Part 1 Enter	the disease or com	plications that caused the	death Dono						IV 20	Approximate
shock, or hea	art failure. List only	one cause on each line.	death. Do no	0.00		-		y arrost,		Interval Between Onset and Death
Immediate Cause disease or condition	on	a Metast	-62	Col	m	Conco	2			6 mat
resulting in death)		Due to (or as a co	onsequence of):						
Sequentially list co	anditions	b								
I if env. leading to in	nmediate	Due to (or as a co	onsequence of):						
Cause (Disease of that initiated event	S	C								
Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last										
	-									
IF FEMALE: 23b. Was deceder	nt pregnant	23c. If yes, outcome of p		2 🗆 Fatanii				4	23d. Date of	delivery
in the past 12 1 □ Yes 2		4 Pregnent at tim		3 ☐ Ectopie 5 ☐ Other				_	Month	Day Year
9 ☐ Unknowr		9 🗆 Unknown								
Part II. Other signi	ficant conditions	contributing to death but n	ot resulting in t	the underlying	g cause giv	ven in Part I.	23e. D	id tobacco u	se contribut	e to the cause of death?
			_				. 1	☐Yes 2[]No 3□	Probably 4 Unkno
							24a. W	lae an	24h Were	autopsy findings availal
		·· ····· ····					- l a	utopsy erformed?	prior	to completion of cause of
		r					1 □ Ye			Yes 2□No
25. Was case refe examiner?		Hospital:			- Ott	26. Place of Dener:				
1 ☐ Yes 2 💆		1. Inpatient			DOA	4 LI Nursing	Home 5 ☐ R			Specify)
27. Manner of Dea 1. ☑ Natural	th 5 Pending	28a. Date of Injury (Month, Day, Ye	e <i>ar)</i> 28b. Tii Inj	ury	28c. Inju Wo		28d. Descri	be how injur	y occurred	
2 Accident	investigation			М	1]Yes 2 □No				
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not b determined		At home, farn	n, street, fact	ory, office		28f. Locatio City or	n (Street an Town, State	d Number of	r Rural Route Number,
U.										
29a. Certifier (Check only one)	1 Certifying Pi 2 Medical Exam	nysician: To the best of miner: On the basis of ex and manner stated	amination and	death occurr or investigati	ed at the t on, in my	ime, date and pla opinion, death oc	ce, and due to curred at the tir	the cause(s) ne, date and	and manne place, and	er as stated. due to the cause(s)
29b. Signature and	title of certifier	1/_		2	9c. Licen:	se number		29d. Dat	e signed (M	onth, Day, Year)
•	11.	1			0	36761	0	Avg	1 12	7,2009
20 Nom	JA	completed course of it.	/H=== 00=\ /=	D.::	,0	A]		1
Name and add	ress of person who	completed cause of death	(item 23a) (T	ype, Print)	0.	Λ	1. 1	1 11	1 -	11000
31. Date filed (Mor	adilya	Toona 1	Signature #	Seton	RYIL	1c, Lun	iderian	c, Me	25410	गाव 2000
or. Date lifet (MOI	AUG 25 2	2009 Lenews	oignature.	bark		,		,	1	

DHMH 17 Rev 1/2001 Dy

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 19, 2009 8:13 AM M Thomas Lee Rippeon August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frederick Frederick 515 North Market Street If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 24, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Mary Land Days Hours Min Months **½** M 2 □ F 88 219-07-0303 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County 10a State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Medical Examinating the nutilied of XXYes 2 □ No Maryland Frederick Frederick Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 515 North Market Street U.S.A. 21701 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Xyes 2 No If Yes, Give Year or Datas 943-1946 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. White 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerical Work Government 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Agnes Lambert Oscar Rippeon ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 515 North Market Street, Frederick, MD 21701 Sharon R. Phelps, daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Olivet Cemetery Aug. 21, 2009 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) ²Keeney and Basford PA Funeral Home M00255 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on pach line. Immediate Cause (Final Deser Physician disease or condition resulting in death) /Medical Due to (or as a conse ence of) Examiner Sequentially list conditions Due to for as a consequence of Examine cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): physician Physician/Medical the as attending IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 I Unknown 9 Unknown signed by t be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 ☐ Unknown 1 Tes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one funeral director, Be Other: 4 Nursing Home 5 1∐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Residence 6 Other (Specify) Certification: To this 27 Maprier of Jeath 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ccident investigation ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

law requires that the death certificate be executed Box 68760. P.0. Division of Vital Records, To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director; After it completely filled in by the funeral

Baltimore, Maryland 21215-0036

6 Could not be determined

Location (Street and Number or Rural Route Number, City or Town, State)

August 19, 2009

29a. Certifier (Check only one) 29b. Signature a

31. Date filed (Month

1 Certifying Physician: To the test of my knewledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)
Robert L. Kaufmann, M.D., 300 West Ninth Street, Frederick, MD 21701

and manner stated.

State

32. Registrar's Signature



2/0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day Year Walter Spencer Jr tugust 5,2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Doctors Community Hospital Lanham Prince Georges 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ F Months Days Hours Min. 242-56-5832 **Director** 69 March 26,1940 NC Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location if Item 27 is marked other then "naturel", or items 23a or 28e-f show or other traumatic event, the Medical Examiner must be nothed Director 1XYes 2 No MD PG Lanham 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 6608 Louise Street Funeral 20706 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No
If Yes, Give 1962 Year or Dates: 1962 - Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ XNo Specify: Black Specify. 2 3 Widowed 4 Divorced 1964 Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Training Supervisor Metro 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Spencer Mary Everette မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6608 Louise Street
Lanham, Md. 20706

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State 19a. Informant's Name/Relationship (Type. Print) permit, Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra Hortense Spencer/wife 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Md. Veterans Cemetery 8/14/09 Cheltenham, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 11. Enter the disease, or complications that caused the death. nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Im pt diate Cause (Final Metastatic **Physician** months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examine Due to (or as a consequence of): Physician/Medical IF FEMALE yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 000 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day, Year) 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nt: If Item 27 is marked other then "naturel", or ite

and burial-tra

the attending physician

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signed be det

page 2 should

has

this

after death Director:

filled in by

Medical

Maryland 21215-0036

Baltimore,

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

To the Hospital of within 24 hours at To the Funerel D completely 4+1

State

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

29b. Signature and title of certify 29c. License number

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

ause of death (Item 23a) (Type, Print) 30. Name and address of person who completed

LUCKRD Suite 100, LANHAM, MD 20706 Good

6 Could not be determined

Registrar

Lynn Saylor Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2009 27236 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Physician/ Month Day August 2, 2009 1015 hrs Cheryl Lynn Saylor Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Clinton Southern Maryland Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Months Hours Days October 8, 1965 Country) Maryland Director 217-70-8690 43 М 2 X F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County 1 X Yes 2 No Adelphi or items 23a or 28a-f show Prince George's Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20783 USA 1836 Metzerott Road, #1224 14. Race - American Indian, Black 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married 2 X No Yes White Yes 2 X No specify: Specify Widowed 4 Divorced Give Yea ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Food Service Wait Staff 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edward Eugene Saylor Sandra Jean McMillen Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ဥ 1836 Metzerott Road, #1224, Adelphi, MD 20783 Sandra Jean DeFeo / Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crematory 8/10/2009 Alexandria, Virginia Donation 5 Other Specify: 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 RAY Rogers 23a Fart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and **Physician** /Medical Death a Multiple Sharp Force Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transi The law requires that the death certificate be executed Physician/Medical AMENDED UNPENDED attending physician or use as the burial Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 signed by the atte 1 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. á 1 Yes 2 V No 3 Probably 4 Unknown Completed has been si 2 should b 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? 1 ✓ Yes 2 No 1 🗸 Yes 2 No page After this certificate 26.Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medical Be Other₄ examiner? Nursing Home 5 Residence 6 Other 1 Yes ٩ 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury FOUND: Day, Year 28b. Time of Injury 28c. Injury at Work? Certification: Subject stabbed and cut FOUND: Natural 1 Yes 2 ✔ No 5 Pending the Funeral Director: Aug 2, 2009 0844 hrs 2 ___ Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 or Town, State) 16402 Baden-Naylor Road, Brandywine, MD Could not be Suicide determined (Specify) Single Family Home 4 V Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number August 3, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Russell Alexander MD. Assistant Medical Examiner 32. Registra s Signa State Registrar

DHMH 17 Rev 1/2001 OCME 2006

	-	For State Registrar	state of Mar	-		tment of H ificate of L				giene Reg. No. 👝	000	0700
Physicia /Medic		Decedent's Name (First, Middle, Last) MATTHEW K	ALEN SWAN	ISON					2. Date of Dea Month AUG	Day Day	Year 09	3. Time of Death
Examin		4a. Facility Name (If not institution, give structure) NATIONAL NAVAL 5. Social Security Number 6. Sex	MEDICAL C	CENTER	thday)	If Under 1 Year	BETHI	ESDA er 24 Hrs.	8. Date of Birt	Me Me	ONTGOM 9. Birth	IERY place (State or Fore
Director		522-71-7859 1™ N Usual Residence of Decedent	2□ F	20	Yrs.	Months Days	Hours	Min.	May 6,	1989	Cold	orado
72 hours after death with the Maryland 'natural', or items 23a or 28a-f show deal Evant ne must be notified at	ector	10a. State 10b. County CA 0range		Lake F						10g. Citizen		10d. Inside City Lim 1 1 Yes 2 □ ntry?
eath with	Funeral Director	27206 Valleymont R	oad Was Decedent Ev	er in U.S.	13. Wa		2630	Origin? (Sp	ecify Yes or No	14. F	USA Race - Ameri	can Indian,
ural", or iten	þ	1 Narried Status 1 Never Married 2 Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:	2007 - 2009	128	Yes 2□No	Specia	an, Puerto ^{fy:} Peru		Spe	Wn	ite
than,	Completed	15. Decedent's Educat (Specify only highest grade of Elementary/Secondary (0-12)	ion ompleted) College (1-4or 5+)		(Give kil	nt's Usual Occup nd of work done of NOT use retired nt Engine	during m i)	ost of work	ing		Business/In	ndustry
and Mental Hygins marked other umatic event,	To Be C	17. Father's Name (First, Middle, Last) Jeffrey C. Swanson					Ana	M. L				
h and rism		19a. Informant's Name/Relationship (Type Jeffrey C. Swanson		27	206	Address (Street of Valleymo	ont	Rd. L	ake For	est, C	A 926	630
Department of Healt Important: If item 2? any injury or other t		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 🗷 Rer 4 □ Donation 5 □ Other (Specify)	noval from State	1	iven	tion (Name of tory or other place Mem Mor	tuar	y 8/1			on - City or To	
Depart Import any inj once.		21. Signature of Funeral Service Licensee	p-			name and Address irphy Fui		Arl	ington,		n Blvd 2203	
hysician /Medical xaminer	Ji.	23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	COMPLIC Due to (or as a	ATIONS consequence	OF I	SLUNT FO						Approximate Interval Betweer Onset and Deatl weeks
physician and the burial-transit	dical Examiner											
e attending d for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	. If yes, outcome o 1 Live birth 2 4 Pregnant at 1 9 Unknown	Fetal death		Ectopic pregnanc Other (specify)	:y			23d.	Date of deli	very Day Year
n signed b	by	Part II. Other significant conditions control	buting to death but	not resulting i	n the und	derlying cause giv	en in Pa	rt I.				the cause of deat bbably 4 ☐ Unki
rtificate has been signed by th tor, page 2 should be detache	Completed	25. Was case referred to medical				_ = = 11	26 PI	ace of Dea	24a. Was auto perfo 1X Yes	psy prmed? 2 □ No	prior to c death?	topsy findings ava ompletion of caus 2 □ No
fter this ce	ion: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	spital: 1 🔀 Inpatier 28a. Date of Injury (Month, Day,	Year)	Time of Injury	28c. Injui Wor	er: 4□ ry at k?	Nursing H	ome 5 ☐ Resi	dence 6 🗆		cify)
s after death. I Director: After the ad in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	JUL 19 20 28e. Place of Injur building, etc.	ry - At home, fa (Specify)		1 2	Yes 2		City or To	Street and Ni wn, State)	umber or Ru	ral Route Number,
Funera Funera tely fille	Medical (29a. Certifier (Check only one) 1 ☐ Certifying Physical Examine 2 ☐ Medical Examine	cian: To the best or r: On the basis of and manner stat	examination a	e, death nd/or inve	occurred at the ti estigation, in my	me, date opinion,	and place death occu	e, and due to the irred at the time	cause(s) an date and pla	d manner as ice, and due	stated. to the cause(s)
within 7 to the comple	Me	29b. Signature and title of certifier	M.D	,		29c. Licens		(CA)		29d. Date si	gned (Month	
2		30. Name and address of person who com	pleted cause of de	ath (Item 23a)	(Type, P		D FO	RCES	INSTITU 20850		PATHO	LOGY
Sta Registr		STEVEN CAMPMAN Ltc 31. Date filed (Month, Day, Year) AUG 1 2 2009	32. Registra	r's Signature	· ·	NOON	יוחד א	rii)	20000			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** LAWRENCE SAYLOR 310 2009 AUgust /Medical 4c. County of Death
PRINCE GEORGE'S 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** LANHAM DOCTORS HOSPITAL Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Days Hours 1 ☑ M 2 □ F 227-34-9184 VIRGÍNIA 30 1931 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examinas must be notified at 1X Yes 2 □ No PRINCE GEORGE'S Director LANHAM MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20706 7105 97th AVENUE Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 No ARMY If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No BLACK Specify: Be Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT ELECTRICAL ENGINEER 2YRS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MINNIE THOMPSON ၉ CHARLIE SAYLOR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7105 97TH AVENUE LANHAM, MARYLAND 20706 GARNETTE F. SAYLOR/WIFE Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ARLINGTON, VIRGINIA 8/27/2009 ARLINGTON CEMETERY 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME of Fundamental Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final unknown **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician; The law requires that the death certificate be executed ng physician and as the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for 5 ☐ Other (specify) P.0. been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 st autopsy performed 1 □ Yes 2 🛶 6 2 No 1 ☐ Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient After this Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident I Director: / 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Division of Vital Records, hours after death. To the Funeral Dir completely filled in To the Hospital

SAYLOR

Medical

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MDD42684

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year) 8-6-2009

RD LANham, MD 20706 Good ZWALLY

(Check only one)

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2009 August 4:17 PM James John Shay /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Berlin Health & Rehab Center Berlin Worcester Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 1 **X** M 2 □ F 88 Pennsylvania Director 171-14-8485 June 13, 1921 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County show 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Eventines must be notified at 1 ☐ Yes 2 X No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20904 501 Whittingham Drive Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Army Year or Dates:1943-1946 Army 1 ☐Yes 2 🕱 No Specify: Specify: Completed by 3 X Widowed 4 ☐ Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TRPAT 12 Director of Jurisdiction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental and 2 should be Margaret Bauman ပ James Shay 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health a
Important: If item 27 is
any injury or other trau 3828 Brooke Meadow Lane, Olney, Maryland 20832 Colleen Swisher - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 🖾 Other (Specify) Entombment 08/10/2009 Silver Spring, Maryland Gate of Heaven Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part 1. Enter the disease Immediate Cause (Final **Physician** disease or condition resulting in death) Cerebrovascular accident /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760, physician Physician/Medical the attending | IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year 5 ☐ Other (specify) signed by the signed for the dispersion of the signer of t □Yes Ö 9 Unknown 9 Unknown 9 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform this certificate 2 XNo 2 🗌 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2∭XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1X Natural 5 ☐ Pending investigation To the river a er death.

Within 24 hours a er death.

To the Funeral Director Af 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide nursing Practitioner
To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signa and title of certifier 🦼 2 August 5, 2009 R135131 30. Name of address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

Pennie Savage,

AUG 10

31. Date filed (Month, Day, Year)

CRNP

James

Shay

9715 Healthway Dr, Berlin, MD

21811

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2009 Year August 7, Physician HAZEL ANN ST. JULIEN 9:40 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Asbury Methodist Village Gaithersburg Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 5/12/21 Birthplace (State or Foreign Country)

LA 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 1 F Yrs. 439-24-5802 88 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, I'm Mudcai Evaniner must be notified at once. 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 No by Funeral Director MD Clarksburg Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12835 Murphy Grove Terr. U.S.A. 20871 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 □Yes ♣ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Peter Toussaint Ferdinand Leah Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Claudell W. St. Julien -husband 12835 Murphy Grove Terr, Clarksburg, MD 20871 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stat Michael Cath. Cem. 8/14/09 | Convent, LA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Snowden Funeral Home, P.A. Funeral Service Licenses 21. Signature 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cerchiovascular /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 ☐ Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by Zures 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 1 □ Yes 1 ∐Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation within 24 hours are: ...
To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

State Registrar 29b. Signature

and title of certifier

John

AUG 11

31. Date filed (Month, Day, Year)

Rupel

who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

29c. License number

The Cei Hu

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar AMEND #23a(a.b)perMD,8-14-09, BMW, MGertificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) - 2<u>009</u> Month **Physician** 7, 17:04 August HELEN JACKSON SHIRLEY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Shady Grove Adventist Hospital Rockville 8. Date of Birth (Month, Day, Year) 5/13/32 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Funeral Min. 1 □ M 2 X F Months Days Hours MD Director 220-34-9153 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County 28a-f show r than "natural", or items 23a or 28a-f sho 1 Tyes 2X No Director MD Montgomery Gaithersburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20878 U.S.A. 120 Cnevy Chase St. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Black 3€ Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within lealth and Mental Hygiene.

m 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Private Nursing Nursing 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Aileen McDonald James Edward Jackson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra 14 Ramsdell Ct, Gaithersburg, MD 20878 Natalie Shirley - daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from 8/13/09 Germantown, MD Seneca Church Cem. 4 ☐ DonaMon 5 ☐ Other (Specify) Funeral Service Li 22. Name and Address of Facility Snowden Funeral Home, P.A. 21. Signatu 246 N. Washington St, Rockville, MD 20850 se, or complications that caused the death. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disea o not enter the mode of dying, such as cardiac or respiratory arrest, Morbid Obesity shock, or heart failure Immediate Cause (Final disease or condition resulting in death) Multiorgan **Physician** /Medical Due to (or as a consequence of): 1 week Examiner Sepsis Sequentially list conditions, if any, leading to him ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Line to for as a consequence of Examiner requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical attending use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy jo Day 5 ☐ Other (specify) signed by the a 9 Unknown O 9 Unknown ₫. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ğ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an The law autopsy performe certificate 1 ∐Yes 2 No 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 XNo 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division or Attending Natural 5 ☐ Pending investigation after death.

Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in I within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number 2

Registrar

DHMH 17 Rev 1/2001

State

9901 Shady Grove Rd, Rockville, MD 20858

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32/Registrar's Signature

10 euro

Shahryar Davari 31. Date filed (Month, Day, Year)

AUG 11

			State of Ma		Department of H			7 H H U	2721.2
	_		Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of I	Death	2 Date of Deat	eg. Nó., UUJ h	3. Time of Death
S. S.	Physicia		Flaceing Anno S	chill	ina		Month	- Day 200	7 455 AM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	11		r Location of Death	Nagar	4c, County of De	
100	LAGIIIII		Potomue Valley Nursing	/ Home	- hock	VIIIe		-	omery
	Funeral		1□M 2⊠E	(In yrs. last bir	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	inthplace (State or Foreign Country)
Star.	Director		135-03-1291 Usual Residence of Decedent	93	Yrs.		May 21,	1916	New Jersey
	/land	1	10a. State 10b. County	10c. City, Tow	n or Location				10d. Inside City Limits
	Man e-f st	io	Maryland Montgomery		Kensington				1 ☐ Yes 2 ☑ No
	or 28	Oire	10e. Street and Number		10f, Zip Code		1	0g. Citizen of What	ŕ
	ath w	iai	3116 McComas Avenue			895	pacify Vas or No-	United S	Tates
	item	Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ N		13. Was Decedent of H If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)	Black, W	
920	urs af		3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify: W	hite
2-0	be filed within 72 hours after death with the Maryland nat Hygiene. ed other then "natural; or iteme 23s or 28e-f show event, the Madical Examinar must be notified at	Completed by	15. Decedent's Education (Specify only highest grade completed)	16a	Decedent's Usual Occup (Give kind of work done	during most of world	king	16b. Kind of Busines	ss/Industry
121	within ene. then.	mpie	Elementary/Secondary (0-12) College (1-4or 5	+)	Mode1	d)		Modelin	σ
2	e filed within at Hygiene. I other then 'vent, I're Ma		1 Z 17. Father's Name (First, Middle, Last)		Model	18. Mother's Nam	ne (First, Middle,	Maiden Sumame)	-6
an	id be fental rked o	To Be	Eugene McCarthy			Anne		Klun	
Maryland 21215-0036	shound N	_	19a. Informant's Name/Relationship (Type, Print)		o. Mailing Address (Street				
	and 2 lealth a m 27 is		Diana Ruskin /Daughter		16 McComas	Avenue; K			
Baltimore,			20a, Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	cemete	of Disposition (Name of ary, crematory or other plan	_ , _	Date	20c. Location - City	
ij	t. Partmen		4 Donation 5 Other (Specify)	Ft. Li	incoln Crema		2/2009	Brentwoo	oa, MD
Ba	permit. Page Department of Importent: if any injury or once.		21. Signature of Funeral Service Licensee		22. Name and Addre			rille, MD	20852
	W.		23a. Part1. Enter the disease, or complications that caused shock or heart failure. List only one cause on each lir	the death. Do					Approximate Interval Between
100	Physician		Immediate Cause (Final disease or condition		nonix				Onset and Death
8 A	/Medical		resulting in death)	a consequence					1000
	Examiner	L.	Sequentially list conditions, b.	a consequence	-B.				
	ted nsit	nine	cause. Enter Underlying Cause (Disease or injury	ii consectaciones	OI)				
Ć.	be executed ician and burial-transit	Examiner	that initiated events c. Pue to (or as	a consequence	of):				
8760,	ate be executed physician and the burial-transit	icai	d						
9	eath certifical attending phy I for use as th	Med	IF FEMALE:						
Вох	ath ce	lan/	23b. Was decedent pregnant 1 Live birth	2 Fetal death	n 3 □Ectopic pregnanc 5 □ Other (specify) _	y		23d. Date of Month	delivery Day Year
P.O.	the de	Physician/Med	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at 9 ☐ Unknown	time of death	5 Other (specify)				
	The law requires that the death certificate ste has been signed by the attending physpage 2 should be detached for use as the	by Ph	Part II. Other significant conditions contributing to death b	ut not resulting	in the underlying cause gr	ven in Part I.	23e. Did to	bacco use contribut	e to the cause of death?
rds	w requires been sign should be	ed b	severe fort	16 3	RNOSIS		1 🗆 Y	′es 2€No 3⊑	Probably 4 Unknown
Records,	e lawre has bee je 2 sho	Completed	Dementia				24a. Was autop	sv prior	autopsy findings available to completion of cause of
æ		Сош	Failure to	Thri	Ve		perfor 1 ☐ Yes	med? death	
Vital	Physician: Th r this certificete ral director, pag	Be	25. Was case referred to medical examiner?		C	han -	ath (Check only o		
of	Phys rthis ral di	. To	27. Manner of Death 28a. Date of Inju	ırv 28b.	utpatient 3 DOA Time of 28c. Injury	4 Mursing r		dence 6 Other (S	Specify)
on	Attending Phy or death. ector: After thi by the funeral of	ation	1 Matural 5 Pending (Month, Da 2 Accident investigation	ý Year)		ork?]Yes 2∐No			
Division	Attendi er death. ector: A by the fu	Certification:	3 Suicide 6 Could not be 28e. Place of Inj	ury - At home, f	arm, street, factory, office		28f. Location (S City or Tow		r Rural Route Number.
Ö	itel or rrs aft rel Di		nurs	e pracx	Litiener				
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the to	Medical	29a. Certifier 1 Certifying Physician: To the best (Check only one) 2 Medical Examiner: On the basis on and manner st	f examination a	ge, death occurred at the t nd/or investigation, in my	ime, date and place opinion, death occu	e, and due to the curred at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	ithin of the omple	Me	29b. Signature and title of certifier		29c. Licen	se number	. ,	29d. Date signed (M	onth, Day, Year)
	[/		> / Wex Hugh	50,1	Unp R	11397	7	August	6 2009
			30. Name and address of person who completed cause of	leath (Item 23a)	(Type, Print)	Milec	UIAR.	D1#20	20.0
	We at		31. Date filed (Month, Day, Year) 32. Registr	ar's Signature	()	Rocku	ille	rnd &	HV850
13	Sta Regist	ate rar	ALIC 11 2000	a a signature	harred.				

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician 9:16 p M August 9 2009 Ann Saportin /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Hebrew Home of Greater Washington Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/01/1916 5. Social Security Number Birthplace (State or Foreign Country) Funeral Hours Months Days 1 □ M 2 🗓 F Poland 92 040-09-9710 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exeminer must be notified at 1X Yes 2 No Director Maryland Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20852 USA 6121 Montrose Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 ☑ No Specify: White 9 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 should be filed with and Mental Hygier 7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic eve ပ Jacob Alpert Esther Caplan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20852 6414 Needle Leaf Drive, Rockville, Maryland Charlene Saportin-Disler, dtr. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 08/11/2009 Ind. Vilner Lodge New Haven, CT 4 □ Donation 5 □ Other (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 Rockville Pike, Rockville, Maryland 20852 MO1255 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner DYSCHAGIA Sequentially list conditions, Due to for as a prosection on the Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last -VASCULAR attending physician and for use as the burial-trar Due to (or as a consequence of): The law requires that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 C Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 2 2100 3 Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? res 2 No certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To thours after death.

cuneral Director: After this ely filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 □Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical

State

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

29b. Signature and title of certifier

31. Date filed (Month

5

0018084

29d. Date signed (Month, Day, Year)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

		•	1 - State of M Registrar	-	epartment of H C <i>ertificate of D</i>			ene g. No. O O O O	07011
			Decedent's Name (First, Middle, Last)				2. Date of Death	4000	3. Time of Death
	Physicia		MAHLON LEWIS	SLAGLI	E JR		Month AUGUST	6, 2009	1:50P M
and and	/Medic Examin		4a. Facility Name (If not institution, give street and number		4b. City, Town, or	Location of Death		4c. County of Deatl	
	LXUIIII		FREDERICK MEMORIAL H	OSPTTAT.	FREDER	RŤCK		FREDERIC	!K
	Funeral		5 Social Security Number 6. Sex 7.	Age (In yrs. last birtho		If Under 24 Hrs. Hours Min.	8. Date of Birth	9. Birtl	hplace (State or Foreign
	Director		217-42-7663 ¹ ₺ м 2□ F	65 Yr	s. Months Days	110013	Aug. 9,	1943 Mar	yland
	D .		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	or Location				10d. Inside City Limits
	aryla sho	'n	,	loc. Oity, lowing					1 □Yes 2 No
	he M	Director	Maryland Frederick 10e. Street and Number		Knoxville	:	10	g. Citizen of What Co	untry?
	a or				701. Zip Code	2175		United S	
	72 hours after death with the Maryland natural", or items 23a or 28a-f show Jital Examiner must be notified at	Funeral	1229 Rosemont Drive 11. Marital Status 12. Was Decede	nt Ever in U.S.	13. Was Decedent of Hi			14. Race - Ame	
, o	fter d r item iner	Fun	Armed Force 1 ☐ Never Married 2 📉 Married 1 ☐ Yes 2 🖟	s? X No	13. Was Decedent of Hi		Rican, etc.)	Black, White	e, etc.
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21215-0036	2 ho	Completed	15. Decedent's Education (Specify only highest grade completed)		Decedent's Usual Occupa			6b. Kind of Business/	Industry
21	thin 7	nple	Elementary/Secondary (0-12) College (1-4c	or 5+)	life. DO NOT use retired,		g	A	04440
7	ed wi	Co	12	Pa	rts Manager		(57)	Autom	orive
<u>n</u>	be fill d oth	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle, M aura Flo]		
3	ould Mer narke	2	Mahlon L. Slagle, Sr.		Mailing Address (Street a				Zin Cada)
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Machinal Examination of the recitifical anonce.		19a. Informant's Name/Relationship (Type. Print) Mary Margaret Slagle / W	1	229 Rosemont				
رة ب	1 and Healt em 2		20a. Method of Disposition		Disposition (Name of crematory or other place		Date 2	20c. Location - City or	Town, State
JO.	ages int of t: If it		1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from Sta	TA I	crematory or other place or Crematory		2009	Frederic	k, Maryland
Ē	artme		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	beautic	22. Name and Addres	1		Funeral Ho	
Ba	Depi Impo any		My trail Sto	will.				ick, MD 21	
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68760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	edical	d						
9 ×	ding se as	/Me	IF FEMALE: 23c. If yes, outcome	me of pregnancy				23d. Date of de	liven
Вох	eath certif attending for use as	ian	in the past 12 months?	h 2 Fetal death	3 Ectopic pregnancy 5 Other (specify)	у		Month	Day Year
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8	The law te has age 2 s	Completed					autops	ned? death?	completion of cause of
ta	an:] tiffica tor, p	Be C	25. Was case referred to medical			26. Place of Dea	1 ☐ Yes 2 th (Check only one		2 🗆 140
<u>></u>	Physician: The this certificate h ral director, page	To B	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inp	atient 2 ER/Out	oatient 3 DOA Othe	er: 4 🗆 Nursing H	ome 5 🗌 Reside	ence 6 Other (Spe	ecify)
Division of Vital Records,	ding Physician: The I h. After this certificate h funeral director, page	L:u	27. Manner of Death 28a. Date of 1. Natural 5 ☐ Pending (Month,		me of 28c. Injury	y at k?	28d. Describe ho	w injury occurred	
<u>.</u>	endir ath. or: At	atic	2 Accident investigation			Yes 2□No			
Ξ	Il or Attend after death I Director: . d in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of building.	Injury - At home, farn , etc. (Specify)	n, street, factory, office		28f. Location (St. City or Town	reet and Number or R n, State)	ural Route Number,
	ital o urs af ral Di lled ir								
	Hosp 14 hou Fune tely fi	ical	29a. Certifier 1 Certifying Physician: To the beautiful Check only 2 Medical Examiner: On the basis	is of examination and	death occurred at the tir /or investigation, in my o	me, date and place pinion, death occu	e, and due to the corred at the time, do	ause(s) and manner a ate and place, and du	is stated. e to the cause(s)
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	one) and manner 29b. Signature and title of certifier	sidieu.	29c. Licens	e number	2:	9d. Date signed (Mon	th, Day, Year)
	F 3 F 8		I CAMINI	10		37/78		8-7-04	
			30. Name and address of person who completed cause of	of death (Item 23a) /7) 11 / 0		7-07	
	12		Christopher Flemin		0 9th Ave.,	Brunswi	ck, MD 21	1716	
	Sta	te	31. Date filed (Month, Day, Year) 32. Reg	istrar's Signature					
	Registr	ar	AUG 11 2009 1/2	A A					

DHMH 17 Rev 1/2001

The content of the	7 2009 6:23 PM c. County of Death Montgomery
No. 200 State St	7 2009 6:23 PM c. County of Death Montgomery
Scalin Name (if not institution, pive stored and number) 40. City, Town, or Location of Death 51. Silver Spring 5. Social Security Number 6. Set 13.0 + 8.2 - 14.74	Montgomery
Silver Spring Silver Sprin	
130-82-1474 130 280 130 280 140 280 130 280 130 280 140 280 130 280 14	Birthplace (State or Foreign
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10a. State 10b. County 10c. City, Town or Location 10b. City, Town or Location 10b. County 10b. City, Town or Location 10b. City, Town or Loca	72 New York
Aime Raymond Tchoua – Husband 733 Sligo Ave., #512, Silver Spring 20a. Method of Disposition 1	10d. Inside City Limits
Aime Raymond Tchoua – Husband 733 Sligo Ave., #512, Silver Spring 20a. Method of Disposition 1	1 □ Yes 2 🔼 No
Aime Raymond Tchoua – Husband 733 Sligo Ave., #512, Silver Spring 20a. Method of Disposition 1	itizen of What Country?
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Aime Raymond Tchoua – Husband 733 Sligo Ave., #512, Silver Spring 20a. Method of Disposition 1	14. Race - American Indian,
Aime Raymond Tchoua – Husband 733 Sligo Ave., #512, Silver Spring 20a. Method of Disposition 1	Black, White, etc. Specify: Black
Aime Raymond Tchoua – Husband 733 Sligo Ave., #512, Silver Spring 20a. Method of Disposition 1	Specify: DIACK
Aime Raymond Tchoua – Husband 733 Sligo Ave., #512, Silver Spring 20a. Method of Disposition 1	Kind of Business/Industry
Aime Raymond Tchoua – Husband 733 Sligo Ave., #512, Silver Spring 20a. Method of Disposition 1	Private
Aime Raymond Tchoua – Husband 733 Sligo Ave., #512, Silver Spring 20a. Method of Disposition 150 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetary, Cemetary, Cemetary, Cemetary, Cemetary, Cemetary, Cemetary, Cemetary, or other place) 20a. Method of Disposition 150 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetary, Cemetary, or other place) 3cm 2cm	n Surname)
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A ime Raymond Tchoua – Husband 733 Sligo Ave., #512, Silver Spring 20a. Method of Disposition 1	or Town State Zin Code)
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A Donation S Other (Specify) Gate of Heaven Cem. O8/22/2009 Sill	Location - City or Town, State
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Physician /Medical Examiner Per condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or condition resulting in death) Last Due to (or as a consequence of): Mediastinal Nodes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due	Approximate
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Under the second	2 ☐ No 3 ☐ Probably 4 ☐ Unknown
Under the second	24b. Were autopsy findings available
Under the second	prior to completion of cause of death?
26. Place of Death (Check only one) 1	
The state of the s	- Con (5)
C B 9 C 1 M2 Natural 5 □ Pending (Month, Day, Year) Injury Work? 1 □ Accident investigation M 1 □ Yes 2 □ No	
To be see Re 2 DACOUGHIL 1 DACOUGHIL	,
Significant Street and Street arm, street, factory, office 28f. Location (Street and All Homiside) 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Street and	and Number or Rural Route Number,
Sign of the second seco	te)
29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s)	(s) and manner as stated.
29a. Certifier 129a. Certifier 29a.	nd place, and due to the cause(s)
29b. Sign Oure and title of certifier 29d. Date 29b. Sign Oure and title of certifier 29d. Date 29b. Sign Oure and title of certifier 29d. Date 29b. Sign Oure and title of certifier 29d. Date 29b. Sign Oure 29d. Date 20d. Date 20d. Date 20d. Date 20d. Date 20d. Date 20d. Date	Pate signed (Month, Day, Year)
Caron Offenducks MJ D37236 Augu	gust 11, 2009
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
Carolyn B. Hendricks. MD. 6410 Rockledge Drive Suite#506, Bethe	nesda, MD 20817
State Registrar AUG 1 2 2009 AUG 1 2 2009 AUG 1 2 2009	
Registrar AUG 1 2 2009 Renews B. Saules	

09-06419 Gregory Jason Temple

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Sour	100	Section	100	Street, Square,		le-ma	- 6	10

Physician/ edical Examiner 1. Decedent's Name (First, Middle,Last) Gregory J. Temp1e 4a. Facility Name (if not institution, give street and number) Line Bridge Road @ Conowingo Reservoir 4b. City, Town, or Location of Death Conowingo Flintville 4c. County of Death Harford 4d. City, Town, or Location of Death Harford 4d. City, Town, or Location of Death Harford	regory bason i	1	- For State	or ivial yland /	Certifica							eg. No.	Steam Nath		the four of
Through the properties of the		ın/	 Decedent's Name (First, Middle, La 								Month	Day	Year	1	
Part	ledical Examil		0 ,			- 4	b. City. Tow	n. or Lo	cation of		August 10		County of Dea	 ath	
Filtred The Control The							Conowi	ngo	F1in	tvi1	.1e	На	rford		
Total Content Total Conten	Funeral	-				hday)	If Under 1	Year			8. Date of Bi	rth(MM/DE	D/YYYY) g. E	Birthplace (Sta	ate or
To State 100 Cocy 100 Convert 100 Conv				XM 2 F	30	Yrs.	Months	Days	Hours	Min.	Oct.	11, 1		Country)	sylvani
Mary Land Cecil Conowingo Conowing	è	ŀ			10c. City, Town	or Location	on							10d. Insid	e City Limits
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1 3 Conowingo Rd. 1 3 Conowingo Rd. 2 19 18 USA 1 Marcia Status: 1 Marcia Status	arylan Sa-f sl	ま					10f. Zip Co	ode				10g. Citize	en of What C	ountry?	
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The second of paperson of the	h with 1 ms 23s		11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was	s Decedent es, specify (of Hispa Cuban, I	anic Origir Mexican, F	n? (Spe Puerto F	cify Yes or No Rican, etc.)	0- 14			Black,
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Physician Madria: The company of	and 2 (ealth tem 2 traum		20a. Method of Disposition		20b. Place	of Dispos	ition (Name	of cem	etery,		Date	20c. Lo	ocation - City	or Town, Sta	te
Physician Madria: The company of	Ore ges 1 rt of H rt of H				ale	•							ina C	un Ma	muz1 and
Physician Madria: The company of	Itim it. Pa urtmer ortani	ì			K.T.	Poar 22. N	lame and A	ddress	of Facility	R.	r.a. T. Foa	rd Fu	ineral	Home.	P.A.
Physician Madria: The company of	Dep Dep De la	0 7	no	1		11	1 S.	Que	en St	. ,	Rising	Sun,	, MD		
The first light of the first lig	Physician		23a. Part I. Enter the disease, or confailure. List ably one cause on	molications that caused	the death. Do n	ot enter t	he mode of	dying, s	uch as ca	rdiac or	respiratory a	rrest, shoo	ck, or heart	Betwee	en Onset and
To Continuous resulting in death) Sequendally list conditions If any, lessing to indentify close (large stat militable events resulting in death) Last Due to (or as a consequence of): Due to (or as a conseq		83	Immediate Juse (Final disease	_											Death
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AMENDED 23a,27,28a-1,perME, G894 8/26/09 TT FEMALE: 23c. fyes, outcome of pregnancy 23c. fy	ted Insit	Exa		d											
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Past 12 months? Type 2 No 9 Unknown	60, ate be hysici e buri	Med					errin,	002	- 07	21,		23d	. Date of del	ivery	
29b. Sign) ture and tytle of certifier O.C.M.E. August 17, 2009 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month Pen Y2) 32. Registrar's Signature	687 ertific ding p e as th			Decrease a	t time of death			3	Ectopic	pregna	ncy		Month	Day	Year
29b. Sign) ture and tytle of certifier O.C.M.E. August 17, 2009 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month Pen Y2) 32. Registrar's Signature	eath c atten for us	/sic	1 Yes 2 No 9 Unkno		t tille of death	5 0	ther (Speci	fy)				82			
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Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month Phy Y2) 2000 32. Registrar's Signature			30. Name and address of person w	no completed cause of	death (Item 23a)									
State 31. Date filed (Month Pig 2)1 2009 32. Rigistrar's Signature			Victor Weedn MD JD				Penn Str	eet, B	Baltimor	e, MD	21201				
			31. Date filed (Month 106 2)1	'/(II K)		1	and	,							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death 451/08 Ronald VAUGHN 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Western Maryland Hospital Center Washington Hagerstown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 X M 2 □ F 63 218 46 9091 May 29, 1946 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TXYes 2 ☐ No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1500 Pennsylvania Avenue 21740 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 1 1/2 Elementary/Secondary (0-12) cook restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Webster Vaughn Pearl Guinsburg 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer Crockett - friend 819 Washington Ave., Apt. 1E, Hagerstown, Md.21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hagerstown Crematory 8/12/09 Hagerstown, Maryland

22. Name and Address of Facility

e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause in each line.

FATLURE

FAILURE

KENAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUG 13 2009

ABBULLAH

32. Registrar's Signature

Due to (or as a consequence of):

MINNICH FUNERAL HOME

Approximate
Interval Between
Onset and Death
I - 2 Mbr THS

08/10/2009

WEEKS

415 E.Wilson Blvd., Hagerstown, Md. 21740

permit. Page Department of Important: If any Injury or once. **Physician** /Medical

Physician

/Medical

Examiner

10a. State

Funeral

Director

items 23a or 28a-f sh ner must be notified

Funeral

þ

2

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Immediate Cause (Final disease or condition resulting in death) Examiner Exam

4 ☐ Donation 5 ☐ Other (Specify)

as

State

Registrar

MUHAMMAD

31. Date filed (Month, Day, Year)

Division or Vital Records, P.O. Box 68760

lical Exami	Cause (Disease or injury that initiated events resulting in death) Last	c. Sefs I. Due to (or as a consequence).						1_2 02
by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnan 1 □ Live birth 2 □ Fetal of the pregnant at time of decent section 1 □ Fetal of the pregnant at time of decent section 2 □ Fetal of the pregnant at time of decent section 2 □ Fetal of the pregnant at time of decent section 2 □ Fetal of the pregnant at time of decent section 2 □ Fetal of the pregnant at time of decent section 2 □ Fetal of the pregnant at time of decent section 2 □ Fetal of the pregnant at time of decent section 2 □ Fetal of the pregnant at time of decent section 2 □ Fetal of the pregnant at time of decent section 2 □ Fetal of the pregnant at time of decent section 2 □ Fetal of the pregnant at time of decent section 2 □ Fetal of the pregnant at time of decent section 2 □ Fetal of the pregnant at time of decent section 2 □ Fetal of the pregnant at time of decent section 2 □ Fetal of the pregnant at time of decent section 2 □ Fetal of the pregnant at time of decent section 2 □ Fetal of the pregnant at time of decent section 2 □ Fetal of the pregnant at time at the pregnant at t	death 3□Ectopi	c pregnancy (specify)			23d. Date of del Month	ivery Day Year
	Part II. Other significant conditions of	ontributing to death but not resul	ing in the underlyin	ig cause given ir	Part I.	23e. Did tobacc		the cause of death?
Completed	HTN					24a. Was an autopsy performed?	prior to death?	atopsy findings available completion of cause of 2 □ No
Be (25. Was case referred to medical examiner?			26	. Place of Death	(Check only one)		
70	1 Ves 2 No	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient 3	DOA Other:	4 🔀 Nursing Hor	ne 5 Residence	6 ☐Other (Spe	cify)
	27. Mannger of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes	2 □ No	28d. Describe how in	jury occurred	
Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At hon building, etc. (Specify)	ne, farm, street, fac	tory, office	2	28f. Location (Street City or Town, Sta		ural Route Number,
Medical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my knowniner: On the basis of examination	ledge, death occur on and/or investigat	red at the time, tion, in my opini	date and place, a	and due to the cause ed at the time, date a	(s) and manner as and place, and due	s stated. to the cause(s)
ž	29b. Signature and title of certifier			29c. License nu	mber	29d. [Date signed (Monta	h, Day, Year)

DO0 64911

1500 Pennsylvania Avenue

Hagerstown, MD

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Of Maryl Registrar		rtment of H tificate of L			ene . No.OTA D. D.	0721.0						
	Dhyaisi		1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death						
	Physicia /Medic		Viola Dodson Washington				August	04, 2009	7:35p M						
j	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Silver	Location of Death		4c. County of Deat Montgomer							
	Funeral		8505 Springvale Road 5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Y		hplace (State or Foreign						
	Director		220-18-3954 1□ M 2☑ F 89 Usual Residence of Decedent	Yrs.	Months Days	Hours Min.	3-26-192	20 Wash	nington,DC						
	sryland show	J.		: City, Town or Lo	cation				10d. Inside City Limits 1★ Yes 2 No						
	he Ma	Director	MD Montgomery 10e. Street and Number	Silver S	pring 10f. Zip Code		10-	. Citizen of What Co							
	with t				20910			ited Stat							
	death ms 2:	Funeral	8505 Springvale Road 11. Marital Status 12. Was Decedent Ever	in U.S. 13. V	Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (Spe		14. Race - Ame	rican Indian,						
936	be filed within 72 hours after death with the Maryland that Hygliene. Ad other than "natural", or items 23a or 28a-1 show event, the Medical Examiner must be notified at	by	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 3 ☑ Widowed 4 ☐ Divorced Year or Dates:		rYes, spectry Cuba I∐Yes 2 <mark>†</mark> ⊈No		Hican, etc.)	Black, White, etc. Specify: Black							
2-0	72 hou natura	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupa kind of work done of	ation		b. Kind of Business/							
Maryland 21215-0036	filed within 7 Hygiene. other than "r ont, the Med	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Secret	DO NOT use retired,)		'ederal Go	vernment						
br	e filed al Hyg other	Be C	17. Father's Name (First, Middle, Last)	1		18. Mother's Name	(First, Middle, Ma								
ylaı	2 should be fi h and Mental H Is marked ot raumatic ever	10	Willie Washington			Ella A	rmour Do	odson							
Mar	s 1 and 2 should by Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type. Print)					City or Town, State, 2							
	1 and 2 Health em 27 I		Breton F. Washington/Son 20a. Method of Disposition		Firma Costilion (Name of natory or other place			.C.A. 9134							
Baltimore,	0		4 □ Donation 5 □ Other (Specify)		ln Cemete	ery 8/12		entwood,							
Baj	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Strvice Licensee	Funeral	Home 20722										
			3a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between												
ā	Physician		Immediate Cause (Final disease or condition resulting in death) a. ADULT FAILURE TO THRIVE Due to (or as a consequence of):												
7	/Medical Examiner		Due to (or as a con	1000	1										
	70 44	ner	Sequentially list conditions, if any, leading to himself and cause. Enter Underlying Cause (Disease or injury that initiated events C. CERESPO												
	ecuted and transii	Examin	Cause (Disease or injury that initiated events resulting in death) Last	VASCULA	RALLID	TUB									
68760,	rificate be executed g physician and as the burial-transit	ledical Ex	Due to (or as a condition of the conditi	abst/uc	tive Pu	Imonar	y DISEA	324							
							7								
O. Box	The law requires that the death cert ate has been signed by the attending bage 2 should be detached for use a	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown 23c. If yes, outcome of provide the pregnant at time end of the pregnant end of the preg	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year						
, P.O.	s that the de gned by the a e detached i		Part II. Other significant conditions contributing to death but not	resulting in the un	nderlying cause give	n in Part I.	23e. Did tobac	cco use contribute to	the cause of death?						
rds	w requires been sign should be	ed by	HYPERCHOLESTEROLENIA				1 ☐ Yes	2 ∕ N o 3 □ Pi	robably 4 ☐ Unknown						
ဝ၁ခ	e law requ has been je 2 should	Completed					24a. Was an autopsy	24b. Were au	utopsy findings available completion of cause of						
<u> </u>		Com					performe	d? death?	2 No						
Vit	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Miss of	Otho	26. Place of Death	(Check only one)								
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence Nursing Home 5 Nursing Home									cify)						
To the state of th								,,							
	I or Atten after deatl Director: d in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - A building, etc. (Sp.	At home, farm, stre pecify)	eet, factory, office		28f. Location (Stree City or Town, S	et and Number or Ru State)	ural Route Number,						
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my 2 Medical Examiner: On the basis of examone) and manner stated and manner stated	knowledge, death mination and/or inv	n occurred at the time vestigation, in my op	ne, date and place, pinion, death occurr	and due to the cau red at the time, date	ise(s) and manner as e and place, and due	s stated. e to the cause(s)						
	To the within 2 To the comple	Mec	one) and manner stated. 29b. Signature and the of certifier		29c. License	number	290	. Date signed (Mont	h, Day, Year)						
	->-0) mo		in	5721,4		18/No/2	2009						
	5		30. Name and a dress it person who completed cause of death	(Item 23a) (Type, F	Print) S COMSIN	- 100	DHEV	CHASE	MD 7/010						
1	/		TIFFINT R. LUCAS MD	5530 NI	sconsin	AVE 114	9	1 3	20615						
	Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's S	ace											

DHMH 17 Rev 1/2001

			For State Registrar	State of Maryla		artment of He rtificate of D			ene2 [] []	9 27249
			Decedent's Name (First, Middle, La	/				2. Date of Death		3. Time of Death
	Physici /Medio		CLARENCE	N. WAL	CER	TIL		Month 08	Day Ye	09 1830 M
	Examir	er	4a. Facility Name (If not institution, glv Hospice of The Ch			4b. City, Town, or L. Annapolis	ocation of Death		4c. County of	
-	Funeral		-	Gex 7. Age (In yrs	. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		Arundel Birthplace (State or Foreign
	Director		214-08-0972	M 2□F 40	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 07/22/19	769 W	ashington, DC
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	Maryta -f sho ied at	tor	MD Prince		dover					1⊠Yes 2 No
	n the	irec	10e. Street and Number	8		10f. Zip Code		10	g. Citizen of Wha	at Country?
	23a c	Funeral Director	2201 Oregon Aver	nue		20785			USA	
	er dea items ner m	une	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,	oanic Origin? (Spo M <i>e</i> xican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc.
336	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ont, the Worksal Examiner must be notified at		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🖾 Divorced	1 ∐Yes 2 ☑ No If Yes, Give Year or Dates:		1 □Yes 2 🙀 No	Specify:		Specify:	Black
21215-0036	72 hou	Completed by	15. Decedent's Ed (Specify only highest gra	ducation	16a. Dece	dent's Usual Occupati	on ring most of worki	na 1	6b. Kind of Busin	ness/Industry
121	within in the series of the se	mple.	Elementary/Secondary (0-12)	College (1-4or 5+)	1	kind of work done dui DO NOT use retired)	ing most of work	ing	D	
	filed w Hygie ther t		12th 17. Father's Name (First, Middle, Last,)	ј ват	ber	8. Mother's Name	(First, Middle, M	Private	
lan	ld be lental ked o ic eve	To Be	Clarence Walker				Daphne 1	•	,	
Maryland	12 should be filed w h and Mental Hygie 7 is marked other ti raumatic event, th	-	19a. Informant's Name/Relationship ((Type. Print)	19b. Mailii	ng Address (Street an	d Number or Run	al Route Number,	City or Town, Sta	ate, Zip Code)
4	1 and 2 Health tem 27 i		Clarence Walker			Oregon Ave			20785	
ore	tges 1 tof H : If iter or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Hemoval from State	-	sition (Name of natory or other place)			0c. Location - Cit	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Widon Examiner must be notified at once.		4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Licer	**		ion Cemete Name and Address	• 1			Maryland
Ba	Dep any concept		Molas	4 Lest	K I	6 Kennedy	00			Funeral Home 20011
			23a Fart 1. Enter the disease, or com shock, or heart failure. List only	plicate his that souse of the dea	th. Oo not en	er the mode of dying,	such as cardiac	or respiratory arre	st,	Approximate Interval Between
24.	Physician		Immediate Cause (Final disease or condition resulting in death)	a. WIDELY ME	ETASTA	TIC ADEN	064570	OCAY	the	Onset and Death
-	/Medical Examiner		resulting in dealin)	Due to (or as a conse	quence of):	TIC ADEN	NE	FAR		
		Je.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consec		, ,	1000			
	ecuted ind transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events list.	c						
58760,	icate be executed physician and the burial-transit	a E	resulting in death) Last	Due to (or as a conse	quence of):					
		edical	•	d						
Вох	leath certifi attending for use as	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet		☐ Ectopic pregnancy			23d. Date of	,
О.	Physician: The law requires that the death certif this certificate has been signed by the attending ral director, page 2 should be detached for use as	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown		Other (specify)			Month	n Day Year
٠ <u>.</u>	that the de ned by the a		Part II. Other significant conditions of	contributing to death but not re-	sulting in the u	nderlying cause given	in Part I.	23e. Did tob	acco use contribu	ute to the cause of death?
rds	w requires been sign should be	ed by						1 ☐ Ye	s 2.0 No 3	☐ Probably 4 ☐ Unknown
of Vital Records,	e law requ has been e 2 shoulk	Completed						24a. Was an	24b. We	re autopsy findings available or to completion of cause of
al B	ician: The certificate h ector, page	Con						perform 1 □ Yes 2	ed2 dea	ath?]Yes 2□No
Vit	sician: certific irector,	Be C	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	I ED/O	Other		(Check only one	111	ANDRING
	ding Phys h. After this funeral di	n: To	27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day, Year)	28b. Time o	II 3 LI DOA	4 LI Nursing Ho	me 5 Aesider 28d. Describe how		(Specify) [77) S/ CC
io	Attending ir death. ector: After by the funer	atio	1 Natural 5 Pending investigation	n	Injury		es 2□No			Music
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Hornicide determined		iome, farm, str ify)	eet, factory, office		28f. Location (Str City or Town,	eet and Number State)	or Rural Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Ph	nysician: To the best of my kn	owledge, deat	h occurred at the time	e, date and place,	and due to the ca	ause(s) and manr	ner as stated.
	he Ho in 24 h he Ful pletely	Medical	(Check only 2 Medical Examone)	miner: On the basis of examin and manner stated.	ation and/or ir	vestigation, in my opi	nion, death occur	red at the time, da	ate and place, and	d due to the cause(s)
	Vith Vith Con	M	29b Signature and title of certifler	Defort.	A	29c. License r	number	. 29	d. Date signed (Month, Day, Year)
			30 Mama and address of several	completed course of death (the	m 23a\ /T	Print)	11730	23	1100	10,0009
12	-6		MICHAEL J.	completed cause of death (Ite	- un	4411	EFENS.	E MIGH	WAyH	Var A POLISM DZIYI
	Sta Registr	_	31. Date filed (Month, Day, Year) AUG 1 2 2009	32. Regietrar's Sign	ature					
	riegisti	211	M							

			For State	State	of Marylar		artment of H				6.	2009	27250
	_		Registrar			Ce	rillicate of t	Deali		2. Date of Dea	leg. No.		3. Time of Death
	Physicia	an l	1. Decedent's Name (First, Middle, L	ast)	. 0 1				'	Month	Day		0950 M
	/Medic	_	Elitabetu		worl	sey		1	CD	80	07	20さら County of Death	0120
	Examin	er	4a. Facility Name (If not institution, gi			,	4b. City, Town, or						
A.			Calvert Memorial	Hospit		lo at hirthday	Prince I			3. Date of Birth		Calvert	place (State or Foreign
	Funeral			5ex 1 □ M 2 💢 F	7. Age (In yrs	. <i>iasi bir triday)</i> Yrs.	Months Days	Hours	Min.	(Month, Day	, Year)	Coui	ntry)
يتنم	Director	ŀ	231-54-6386 Usual Residence of Decedent		67					02-20-1	1942	VILE	inia
	land t		10a. State 10b. County		10c. C	ity, Town or Lo	ocation						10d. Inside City Limits
	Mary f sho	0	MD Calver	t			Chesapeal	ko Re	each				1 ☐ Yes 2 No
	the 1 28a- notif	Director	10e. Street and Number				10f. Zip Code	ic be	- COLI		10g. Citiz	zen of What Cou	ntry?
	with ta or	ō	8779 St. Andrews	Drive				732				USA	
	eath	Funeral	11. Marital Status		cedent Ever in l	J.S. 13.	Was Decedent of H If Yes, specify Cuba		origin? (Spec	ify Yes or No-		14. Race - Ameri	
	iter d	들	1 □ Never Married 2 🕅 Married	Armed F 1 ☐ Yes	orces? 2 X 1 No			an, Mexica	an, Puerto P	tican, etc.)		Black, White,	etc.
2	irs af	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or I	ive -		1 ☐ Yes 2 💢 No	Specify	y:			Specify: wh:	ite
5	2 hou		15. Decedent's I	Education			dent's Usual Occup				16b. Kii	nd of Business/Ir	dustry
2	n "n Nedi	Completed	(Specify only highest g		(1-4or 5+)	life.	kind of work done of DO NOT use retired	auring mo d)	ost of workin	g			
7	t with	E	12	Concgo	(1 101 01)	hor	nemaker				OW	n home	
2	othe ent,	Be C	17. Father's Name (First, Middle, Las	st)				18. Moth	her's Name	(First, Middle,	Maiden	Surname)	
<u> </u>	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	To B	General Lee Crea	sy				B1	Lanche	Eliza	abet	h Thomas	3
3 Z	shound No mark		19a. Informant's Name/Relationship	(Type. Print)		19b. Maili	ng Address (Street	and Num	ber or Rural	Route Numbe	er, City o	r Town, State, Zi	p Code)
Ž	D # 17 # 0		Everett M. Worle	y, spo	use	8779	St. Andre	ews I	Drive,	Chesa	peak	e Beach,	MD 20732
บ์	s 1 and 2 f Health item 27 other tra		20a. Method of Disposition	<u>, , , , , , , , , , , , , , , , , , , </u>	20b.	Place of Disp	osition (Name of matory or other place			ate		cation - City or T	
5	Pages nent of l ant: If its		1 ☐ Burial 2 【X Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	☐Removal fron	n State Me		itan Crem		v 08-1	2-09	A1e	xandria	. VA
Dallinor	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		21. Signature of Funeral Service Lic			<u>_</u>	2. Name and Addre						
0	permit. Departr Importa any Inju		1 4/0h an	2.6	1	ع ا ر	3325 Mt. H	Harmo	ony La	ne, Ow:	ings	. MD 207	'36
Į,			23a. Part1. Enter the disease, or co	mplications that	caused the dea						_	27 - 1	Approximate
	1000		shock, or heart failure. List on Immediate Cause (Final	ly one cause on	each line.	2.1							Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. hi	o (or as a conse	Surfar	e					-	ach ?.
	Examiner			N.J.	(or as a conse	quence oi).	Long (7	- 22				mantes
		Ē	Sequentially list conditions, if any leading to immediate	b. Due to	o (or as a conse	quence of):	1000		-				
	ited nsit	ii.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				•						
В.	xecu and	Examine	that initiated events resulting in death) Last	cDue to	o (or as a conse	quence of):							
00/0	cate be executed physician and the burial-transit	dical E		g.									
000	ficate phys	ğ											
×	certi	Š	IF FEMALE: 23b. Was decedent pregnant		utcome pf preg							23d. Date of deliv	very
Z D D	eath atter	clar	in the past 12 months?		birth 2 Fe gnant at time of		□Ectopic pregnancy □ Other (specify) _	У				Month	Day Year
ċ	ding Physician: The law requires that the death certific n. After this certificate has been signed by the attending p funeral director, page 2 should be detached for use as	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□Unk									
7	that led by deta		Part II. Other significant conditions	contributing to	death but not re	sulting in the	underlying cause giv	en in Par	t I.	23e. Did to	obacco u	use contribute to	the cause of death?
CS	uires sign d be	d by	acarle on	al fai	love,	CAD	, Dog.	47		120	Yes 2	□ No 3 □ Pro	obably 4 □Unknowr
ecords,	v req beer shou	Completed					•			24a. Was	an	24b. Were au	topsy findings available
Į.	The law ate has b	m									osy rmed2	death?	topsy findings available ompletion of cause of
VIIal	r: Th		05.14	1						1□ Yes	2 No	1 Tyes	2□No
 	sicial certii recto	Be	25. Was case referred to medical examiner?	Hospital: 4	-d		nt 30 DOA Oth	nor:		(Check only o			
0	Phys this al dii	J.	1 Yes 2 No 27. Manner of Death	1	Inpatient 2	ER/Outpatie	III OLI DON	4 🗆 1		ne 5 ∐ Resi		6 □Other (Spec	eify)
	ding After fune	ion	1 Natural 5 ☐ Pending	(Mc	onth, Day Year)	Injury	Wor	rk?]Yes 2[.,	
UNISION	ttenc leath tor: the	cat	3 Suicide 6 Could not	h -	ce of injury At	home farm si		J 163 2		28f Location (Street ar	nd Number or Ru	ral Route Number,
\leq	or A	Certification:	4 ☐ Homicide determine	ed buil	lding, etc. (Spec	cify)	reet, factory, office		-	City or To	vn, State	e)	147,10010 113111001,
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, to	Ö	29a. Certifier 1 Certifying	Physician: To t	he hest of my k	nowledge dea	th occurred at the ti	ime date	and place a	and due to the	cause(s	and manner as	stated.
	Hos 24 ho Fun Fun	ledical	(Check only 2 Medical Ex	aminer: On the	basis of exami	nation and/or i	nvestigation, in my	opinion, d	death occurr	ed at the time,	date an	d place, and due	to the cause(s)
	thin the	Mec	29b. Signature and title of certifier		annor stated.		29c. Licens	se numbe	er		29d. Da	ite signed (Monti	n, Day, Year)
	F > F 8		1020	1	-		000	0617	283		5	7/1/5	9
	10/10				05 de 10 00	00-1 /7						/_/_	(
	C.		30. Name and address of person wh	io completed ca	use or death (It	ein ∠3a) (Type L∧cDi⊤∧1	PAR.	PPINA	I CPK	D min	201	107 8	
	Sta	to	31. Date filed (Month, Day, Year)	32.	Aegistrar's Sig	natuje /	, Print) - ROAD,	· NITTO	18/5	17,111	5-01	<i>V</i> (<i>V</i>	
	Registi		AUG 10	2009 1	mur	D. 19	arks						
			הטע – י ו	-000									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 2027 M Dorothy 2009 Warfreld August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore University of Maryland Medical Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Yes) | 8. Date of Birth (Month, Day 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year) 1926 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 XF Maryland 218-20-9092 Director 82 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, Un Medical Evan, in ust be notified at 1 ☐ Yes 2 No Dorchester Cambridge Director MD 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code should be filed within 72 hours after death with USA 21613 5472 Ragged Point Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: Black. White, etc 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 □Yes 2K No Specify: Completed by Specify: White 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) i and Mental Hygiene. Elementary/Secondary (0-12) office worker laundry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elsie Marshall Albanus Ruark ၀ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 21804 4064 Oakland School Rd., Salisbury, MD Ronald L. Warfield son other t 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of Hi
Important: If iten
any injury or oth 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Spedden Seward Cem. 8/14/09 Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 10-10. 700 Locust St., Cambridge, MD 21613 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Possible cardiac tamponade disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dissemnated intravascular coaquilation Examiner or Attending Physician: The law requires that the death certificate be executed Presumed (umphomo Due to (or as a consequence of): burial-tran and Division of Vital Records, P.O. Box 68760, signed by the attending physician be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day 5 Other (specify) should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe After this certificate 2 No 1 □ Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1□Yes 2□No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Man of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the i 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Flural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier mo 9,2009 22955 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street Battimore, MD 21201 22 South Greene Kelly Norsworthy 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 12 2009 Registrar

Baltimore, Maryland 21215-0036

			ype or Print in I					_	
		1 _ State	State of Marylar		nent of F cate of				
	91	Registrar 1. Decedent's Name (First, Middle, Last)		Oerun	cate or	Death	2. Date of Death		3. Time of Death
Phys /Me		Patricia Spear Wil	.ley				August	8 2009	12:00 PM
Exan		4a. Facility Name (If not institution, give s	reet and number)	4b.	City, Town, o	r Location of Death		4c. County of Death	1
		4793 Maple Dam Roa		1 11 11 1 1 1	Cambri		0 0-1 7 01-11	Dorches	
Funera		5. Social Security Number 6. Sex 1□	7. Age (In yrs.		Under 1 Year onths Days	Hours Min.	8. Date of Birth (Month, Day, Sept. 17	9. Birth Con 1938 Ma	pplace (State or Foreign intry) ryland
Directo	r I	Usual Residence of Decedent			<u> </u>			, , , , , , , , , , , , , , , , , , , ,	
Maryland -f show ied at	_	10a. State 10b. County Dorchest		ty, Town or Locatio	n Cambr	enh ir			10d. Inside City Limits
he Ma	ecto						1.0	- 634	1 ☐ Yes 2 XNo
d 21215-0036 // filed within 72 hours after death with the Hygiene han "natural", or items 23a or 28a orther than "natural", or items 23a or 28a orther than Medical Examiner must be notified.	Funeral Director	10e. Street and Number 4793 Maple Dam Ro	ad	1"	0f. Zip Code	21613	10	g. Citizen of What Cou USA	inu y ?
ms 23	Jera	-	2. Was Decedent Ever in U	J.S. 13. Was	Decedent of H	dispanic Origin? (Spi an, Mexican, Puerto	ecify Yes or No-	14. Race - Amer	
6 after or itel	Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give	1	s, specify Cub r∕es 2⊠No		Hican, etc.)	Black, White	, etc. hite
21215-0036 and within 72 hours affigiene. er than "natural", or the Medical Exami	d by	3 XWidowed 4 ☐ Divorced	Year or Dates:			. ,		, ,	
15-1 n 72 h "nati	lete	15. Decedent's Educ (Specify only highest grade	completed)	16a. Decedent's (Give kind life, DO N		oation during most of work d)	ing	6b. Kind of Business/I	ndustry
212 I withinglene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		nomemak			own home	
e filed al Hyg othe	Se C	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, M	aiden Surname)	
ylar ylar build b Ments arked	To Be	Edgar B. Spear	·			Sarah			
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Typ Katherine Gullion	,	1		and Number or Run am Road,		City or Town, State, Z e • MD 216	
e, land 1 and Health em 27		20a. Method of Disposition		Place of Disposition cemetery, cremato.		·		Oc. Location - City or	
Baltimore, permit. Pages 1 a Department of Her mportant: If Item any Injury or othe		1 ☐ Burial 2 【Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		cemetery, cremato. lisbury C				Salisbury,	
Baltimo permit. Page Department Important: If any Injury or	ų į	21. Signature of Funeral Service License			me and Addre			eral Home	
m Ferri	200	B-K.B	>	70	0 Locu	st St., C			
		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	eations that caused the dea	th. Do not enter th	e mode of dyir	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between
Physicia		Immediate Cause (Final disease or condition resulting in death)	Monk	o emb.	plic	Diser	se		Onset and Death
/Medica	-	resulting in death)	Due to (or as a consec	quence of):					
	e e	Sequentially list conditions, if any, eaching to in mediata cause. Enter Underlying	Due to (or as a conse)	quence of):				- 3	
uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
0, e executed an and urial-transit	Exa	resulting in death) Last	Due to (or as a consec	quence of):					
6 6 6	lical	d							
, P.O. Box 687 that the death certificate ed by the attending phys detached for use as the	Physician/Medica	IF FEMALE:	c. If yes, outcome pf pregn	ancv				001.51.71.5	
Box leath cert attending	cian	in the past 12 months?	1 Live birth 2 Fet 4 Pregnant at time of	al death 3 □Ect	opic pregnanc ner (specify)_	у		23d. Date of deli Month	very Day Year
P.O.	hysi	1 ☐ Yes 2 ☑ Mo 9 ☐ Unknown	9□Unknown						
ds, Puires that signed to be det		Part II. Other significant conditions con	A	•		ven in Part I.	23e. Did tob	acco use contribute to	the cause of death?
cord w require been signshould to	ted	Emphesema,	COCONACT Ar	tery Wis	5845e	, Hapecliped	1 Ye	s 2 No 3 X €	obably 4 □Unknown
Records, the law requires the has been signed age 2 should be considered.	Completed by	Hypochension Ash	hma , Colon	Polyps	OSK	opotosis,	24a. Was an autopsy	prior to c	topsy findings available completion of cause of
Vital Fisions: The certificate		Osteoach ritis	•	·/			perform 1□ Yes 2	ed? death? ZiNo 1 ☐ Yes	2 1468
or Vital Physician: T this certificate ral director, pa	Be	25. Was case referred to medical examiner?	ospital:	15D/O: ttit	DCA Oth	OF.	h (Check only one	,	
OF BPhyser this eral di	ا <u>د</u>	27. Manner of Death	28a. Date of Injury	ER/Outpatient 3 28b. Time of	28c. Inju	4 Li Nursing Ho	28d. Describe ho	nce 6 Other (Spec w injury occurred	cify)
Division of or Attending Fater death. Director: After d in by the funeral	Certification:	1 Defeatural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		Yes 2 □ No			
Divis	tific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At h building, etc. (Speci	nome, farm, street,	factory, office		28f. Location (Str. City or Town,	eet and Number or Ru State)	ral Route Number,
Dital ours aff			T- M- L- A-f						
Division or Vital R To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my kn er: On the basis of examin and manner stated.	ation and/or investi	igation, in my	opinion, death occur	red at the time, da	use(s) and manner as ite and place, and due	to the cause(s)
To the round of th	Me	29b. Signature and title of certifier			29c. Licens	se number	29	d. Date signed (Monti	n, Day, Year)
		1 (gra)	/- D.O	,	144	4615		8/11/9	
3		30. Name and address of person who con	poleted cause of death (Ite	m 23a) (Type, Print	mble	SH CA	mb ride	1 Inh	
	tate		32. F egistrar's Sign					5 MU	
Regi		31. Date filed Month of 12 200	10 Conour	A. box	del				
DUMIL 47. D	(0.001								

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** July 3 I Day 2009 Rose Wallace 1:30 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heritage Harbour Health & Rehab Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth Apr 14 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 936 Hours Days 1 □ M 2 1 F Min. 212-32-5107 Mary land 73 Yrs. **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Exprint. 10d. Inside City Limits 10a, State 10c. City, Town or Location Director TYTYes 2 □ No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 210 Admiral Dr. 21401 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian. Black, White, etc 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ If Yes. Give Specify: Black 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th 0 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kermit Haves ၉ Annie Siscoe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernard Wallace (Husband) 210 Admiral Dr. Annapolis, Md. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemeter). Crematory or other place) Date Department of Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Memorial Park 8-6-09 4 ☐ Donation 5 ☐ Other (Specify) Annapolis, Md. 21. Signature of Funeral Service Licenses Winhame Redere of &acilisons Mortuary, P.A. M00482 821 West St. Annapolis, Md. 21401 Tarry 23a. Part 1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ing. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-transit Due to (or as a consequence of) Physician/Medical use as the 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 □Yes 2 No Month Day Year 4 ☐ Pregnant at time of death
9 ☐ Unknown 5 Other (specify) director, page 2 should be detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 □Yes Division of Vital 1 ☐ Yes Be (25. Was case referred to finedical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA the funeral 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number mpleted cause of death (Item 23a) (Type,

State Registrar

31 Date filed (Month, Day, Year)

AUG 10

P.O. Box 68760.

32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month Physician /Medical 2:04 A M Avaust 2009 Horia 07 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** The Johns Hopkins Hospital Baltimore City If Under 1 Year If Under 24 Hrs.

Months Davs Hours Min. 5. Social Security Number 6. Sex Age (In vrs. last birthday, Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🏋 F Days Canada 49 106-50-7641 3/15/1960 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

nt: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 XYes 2 No Director Maryland| Anna Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 21403 USA 416 Riding Ridge Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2X XMarried Maryland 21215-0036 Specify: White 1 Yes 2 X No Specify: If Yes, Give Year or Dates þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <u>John Hopkins Hospital</u> 5+ Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kenneth Williams Marilyn Bailey Department of Health and Ments Important: If item 27 is marked any injury or other traumatic evence. ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) William White - Husband 416 Riding Ridge Road, Annapolis, MD 21403 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2XXCremation 3 Removal from State 8/11/2009 | Baltimore, MD Baltimore Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home, Inc 21. Signature of Funeral Service Licensee 147 Duke of Gloucester St, Annapolis, MD 21401 Much T. Webel 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final neart failure **Physician** disease or condition resulting in death) /Medical Due to (or as consequence of): Examiner cardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: nse (23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Year in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) d by the at detached 1 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed should be d ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be director, page 2 s autopsy performed' 1 ☐ Yes 2 ☐ No 2 1 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 \sum Nursing Home 2 **⊡**-No 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) ၉ 24 hours after death.

Funeral Director: After this letely filled in by the funeral 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: (Month, Day Year) 1 Matural 5 Pending investigation Injury 2 🗌 No 1 Yes 2 Accident 3 Suicide Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only completely one) within 2 To the I the 29c. License number of certifie 29b. Signature a

State Registrar DHMH 17 Rev 1/2001

park

who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Rushing

Gregory

RES 000

August 07, 2009

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-06047 State of Maryland / Department of Health and Mental Hygiene Richard Langhorne Wilson, III Certificate of Death 1- For State Rea. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Month Day August 3, 2009 Physician/ 0737 hrs Medical Examiner RICHARD LANGHORNE WILSON, III c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's 600 Carson Avenue If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreign Hampton, Hours Months Days Director April 14,1978 Virginia 1 X M 2 31 Yrs 535-06-0869 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State Yes 2 X No 28a-f show Woodbridge items 23a or 28a-f shovest be notified at once. Prince William VA with the Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 22191 ö 1410 Mary Street 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Funeral 11. Marital Status must be White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? permit. Pages I and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene.
Important: If iten 27 is marked other than "natural", or item injury or other tranmatic event, the Medical Examiner must b injury or other tranmatic event, the Medical Examiner must b Never Married 2 X Married 1 X Yes No to Yes 2 X No specify: Specify: Black Yes, Give Year 2009 Widowed Divorced ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Army National Guard Baltimore, MD 21215-0036 2 Soldier 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Philicia Jefferson Richard Langhorne Wilson, Jr. Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13038 Lashmere Court, Woodbridge, VA Charnita Allen -Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Triangle, VA 8/11/2009 Quantico National Other Specify: Donation 5 22. Name and Address of Facility 8914 Quarry Road 21, Signature of Funeral Service Licensee 500208 Bernard O. Ames Domos Cohrner 20110 Manassas, VA Ames Funeral Home, Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. Death /Madical a. Gunshot Wounds (2) of Head and Chest Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical sician a AMENDED UNPENDED 23d. Date of delivery Box 68760 attending physicor use as the bu IF FEMALE 23c. If yes, outcome of pregnancy Year Month Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death past 12 months Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. Yes 2 V No 3 Probably 4 Unknown ş Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? After this certificate has 2 No 1 🗸 Yes Yes 2 26 Place of Death (Check only one To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medica Division of Vital Be examiner? Hospital: 1 Other₄ Residence 6 V Other: Scene DOA Nursing Home 5 ER/Outpatient 3 Inpatient 2 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Subject shot Certification: Aug 3, 2009 0729 hrs Natura Yes 2 V No Pending Director: 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be or Town, State) 600 Carson Avenue, Oxon Hill, MD Suicide within 24 hours a To the Funeral I determined (Specify) Parking Lot 4 V Homicide 29a. Certifier 1 (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier August 4, 2009 O.C.M.E. - 1 1000

State Registrar

DHMH 17 Rev 1/2001

OCMF 2006

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Donna M. Vincenti, MD

AUG .

31. Date filed (Mc

Assistant Medical Examiner

Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1322 P M 04, 2009 August Jane Neagle Whalen 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Suburban Hospital Bethesda 9. Birthplace (State or Foreign Country)District of Columbia If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Months Min 1 □ M 2 F 08/01/1925 84 579-24-4114 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2x No MD Montgomery North Bethesda 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20852 5409 Golf Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 1 Never Married 2 X Married 1 ☐ Yes 2 🔼 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Camille Rabbitt Elmer Neagle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5409 Golf Lane North Bethesda, MD. 20852 Robert J. Whalen (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition Date August 07. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, MD. 4 ☐ Donation 5 ☐ Other (Specify) 2009 Cemeterv 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Liven ee TRACIS MURA 10 East Deer Park Drive Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Physician /Medicai Examiner Division of Vital Records, P.O. Box 68760,

Physician

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d other than "natural", or items 23a or 28a-f sho event, the Medical Empirer must be notified at

Pages 1 and 2 should be filed within 72 hours after on the filed within 47 beauth and Mental Hygione. and the filed and 17 is marked other than "natural", or itel any or other traumatic event, IT. Marical Expension, ny

Department of Health Important: If item 27 any injury or other trong once.

Baltimore, Maryland 21215-0036

the Maryland

death with

Hospital or Attending Physiclan: The law requires that the death certificate be execute attending physician and for use as the burial-trar cate has been signed page 2 should be det

Whalen, Jane 814/09

al Examiner	of CC
ation: To Be Completed by Physician/Medical	iF 2:
y Ph	Pa
Completed b	_
Be	2
ation: To	2

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Mauro Sarmiento M.D.

AUG 11

disease or condition resulting in death)	Ci.	ふして				hors		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence c. Due to (or as a consequence c. d.	e of):				hours		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dee 4 ☐ Pregnant at time of death 9 ☐ Unknown				23d. Date of de Month	elivery Day Year		
Part II. Other significant conditions of	Δ.	j in the underlying cau ર, મિ.	se given in Part I.			to the cause of death? Probably 47 Onknown		
CURRY NEW	Diserte			24a. Was an autopsy performed?	death?	autopsy findings available completion of cause of s 2 No		
25. Was case referred to medical			26. Place of De	ath (Check only one)				
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☑Inpatient 2 ☐ ER/	Outpatient 3 DOA	Other: 4 Nursing	Home 5 ☐ Residence	6 ☐Other (Sp.	ecify)		
27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	(Month, Day, Year)	28a. Date of Injury (Month, Day, Year) 28b. Time of Nork? M 28c. Injury at Work? 1 Yes 2 No						
3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, o	office	28f. Location (Street City or Town, Sta	and Number or F ate)	Rural Route Number,		
29a. Certifier (Check only one)	ysician: To the best of my knowled niner: On the basis of examination and manner stated.	dge, death occurred at and/or investigation, i	the time, date and place n my opinion, death occ	ce, and due to the cause curred at the time, date a	e(s) and manner and du	as stated. ue to the cause(s)		
29h Signature and title of certifier	,	29c.	License number	29d. [Date signed (Mor.	nth, Day, Year)		

State Registrar

24 hours after deatl Funeral Director: filled in by

To the Hosp within 24 ho To the Fune completely f

46895

8600 Old Georgetown Road Bethesda, MD. 20814

4,2009

141

Jarmanto 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

neila Walker		State of Mary 1-For State Registrar		artment of rtificate of		na Ment		Reg. No.	20	09 2725	
Physicia ledical Exami	an/	1. Decedent's Name (First, Middle,Last) Sheila Anne Walker			_		2. Date of I Month August	Death Day 2, 2009	Year	3. Time of Death 1530 hrs	
		4a. Facility Name (if not institution, give street and Prince George's Hospital	number)	4	b. City, Town,	or Location o		4c. (County of D		
Funeral Director		Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1 Y	ear If Unde	Min	·	Fo	Birthplace (State or or oreign Country) DC	
	ŀ	579-56-6330 1 M 2 X Usual Residence of Decedent		Yrs.	<u> </u>		1 //3	0/1942			
ow any		10a. State 10b. County		, Town or Locati						10d. Inside City Limits 1 X Yes 2 No	
Aaryland 28a-f show 1 at once.	Director	DC 10e. Street and Number	W	ashingt	On 10f. Zip Code)		10g. Citize	en of What	Country?	
ith the M 23a or 2 notified		200 Rhode Island Ave,	#214, NE		20002			Uni	ted S	tates	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. nnt: If item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at once	Funeral	1 X Never Married 2 Married Armed 1 Ye		U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- lf Yes, specify Cuban, Mexican, Puerto Rican, etc.)					White, e	frican	
rs after ural", miner	à	3 Widowed 4 Divorced If Yes, Give or Dates: 15. Decedent's Education (Specify only highest or Dates)			Yes 2 X I		kind of work done			nerican ess/Industry	
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner	Completed	Elementary/Secondary (0-12) Colleg	during m	ost of working I	life. DO NOT	use retired)			Government		
5-0036 fled within 7: Hygiene. I other than	Con	17. Father's Name (First, Middle, Last)	· · · · · · · · · · · · · · · · · · ·			18.Mother	's Name (First, Midd	lle, Maiden S		oo veriment	
2121: ould be fil Mental I marked ic event,	Be	Alonzo M. Walker 19a. Informant's Name/Relationship (Type, Print)		19b Mailing	Address (St	and the second	lian V. D		y or Town	State Zin Code)	
MD 2 d 2 shou Ith and M n 27 is n	۵	Lucy B. Holmes/Friend			•		NE, Washi		-	20002	
re, rate, rate of Healt free free free free free free free fre		20a. Method of Disposition 1 X Burial 2 Cremation 3 Remove		Place of Dispos crematory or oth		cemetery,	Date	20c. L	ocation - Ci	ty or Town, State	
Baltimore, permit Pages I at Department of Her Important: If ite		4 Donation 5 Other/Specify:		Nation			8/13/20				
Bal permit Depar Impor injury		21. Signature of Fun. al Sylice Licensée	60050	11/1-1			McGuire venue, NW			rvice, Inc.	
Physician		23a. Part I. Enter the disease, or complications the failure. List only one cause on each line.	at caused the death								
/Medical xaminer		Immediate Cause Final disease a. Multiple	Injuries as a consequence o	-1\.						Death	
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		30. Name and address of person who completed Ling Li, MD Assistant Medical E		^{m 23a)} 1 Penn Stree	et. Baltimor	e. MD 212	201				
St Regis		31. Date filed (Month, Day, Year)				_, <u> 12</u>					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed

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Department of Health and Mental Hygiene. Important, or items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it will will be notified at once.	d by Funeral	11. Marital Status 1 □ Never Married 2 3 □ Widowed 4 □ □		12. Was Deci Armed Fo 1 Yes If Yes, Gi Year or D	νe νe	J.S.		as Decede es, speci	_	ispanic Or an, Mexical Specify:		ecify Yes or Rican, etc.)	No-		ack, White,	ican Indian, , etc. nite	
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1		30. Name and address of Dr. W	person who illian	completed caus n Harpen	se of death (Ite	om 23a) (T 0 Th	ype, Pri Omas	Joh	nsoı	n Dr.	Fre	deric	c, M	D 217	702		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 8, 2009 Ø6:23PM AUGUST Wallace William Gordon /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a, Facility Name (If not institution, give street and number) Examiner Baltimore Saint Joseph Medical Center 8. Date of Birth 1/24/1923 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 🔀 M 2 🗆 F Canada 86 Director 377-12-8702 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental hygiene. nnt; If Item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c, City, Town or Location 10a State 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Predict Extraction in an intention indiffice at 1 ☐ Yes 2 X No Harford Bel Air Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21015 1609 Dogwood Lane Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? ²□No WWII 1 Never Married 2 X Married 1 XYes 2 No WWI.
If Yes, Give
Year or Dates: Korea Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) U.S. Army Military 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Wallace Unknown ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1600 Document In Bel Air, MD 21015 19a. Informant's Name/Relationship (Type. Print) Bel Air, MD 1609 Dogwood Ln. Dolores Wallace (Spouse) permit. Pages 1 and 3 Department of Health Important: If Item 27 I any injury or other tra once. Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 8/21/09 Bel Air, Maryland 5-5 Other (Specify) Bel Air Mem, Gdns. 4 Donation 22. Name and Address of Facility Fineral Se 21. Signatu Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 dance 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate terval Between Onset and Death Immediate Cause (Final Physician CARDIOGENIC SHOCK disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner INFARCTION ACUTE MYOCARDIAL if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician; The law requires that the death certificate be executed SEVERE CORONARY DISEASE burial-tran Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical the r as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown s been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performe 1 ☐Yes 2 No 1 ☐ Yes 2 🕱 No 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Be Other: 4 \sum Nursing Home 5 \sum Residence 6 \subseteq Other (Specify) Hospital: 1 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certif D24034 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year,

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Registrar's Signature

M.

OSLER DRIVE TOWSON, MARYLAND 21204

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29a. Certifier (Check only one) 29m Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Begistrar's Signature	SIO	tendir eath. or: Af the fur	catic	2 Accident investigation		M 1 🗆	Yes 2 □No			D 15 10 10 10 10 10 10 10 10 10 10 10 10 10
29a. Certiffier (Check only one) 29a. Certiffier (Check only one) 29a. Certiffier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Ž	or At after d Direct in by	ərtifi	Zoe, Place of Injury - /	At home, farm, s pecify)	street, factory, office				Hurai Houte Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FARID IN J N S IN ED State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		bspital hours ineral y filled		29a. Certifier 1 Certifying Physician: To the best of my	knowledge, der	ath occurred at the til	me, date and place	, and due to the c	ause(s) and manner	as stated.
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FARID IN J N S IN ED State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		the Ho in 24 the Fu	ledic	one) and manner stated.	mination and/or					
		Viit No 1	2	29b. Signature and title of certifier		29c. Licens	e number		OS IV	o S
				30. Name and address of person who completed cause of death	(Item 23a) (Type	e, Print)	001	00	7	
	5	4-5		- 2 - 1 10 6 11	ED		26 0	1 dh	aw	2740
Registrar AUG 13 2009 / Remains August 19 19 19 19 19 19 19 19 19 19 19 19 19				31. Date filed (Month, Day, Year) AUG 13 2009 32. Registrar's S	Signature	back	Arges 5		1	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- For State of Maryland / Department of State of Maryland / Certificate of		ental Hygiene		27261
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Nichael D. Yacovone		2. Date of Death Month Da	7 2009	3. Time of Death
4	Examin Funeral Director	er		Hours Min.	8. Date of Birth (Month, Day, Year)		place (State or Foreign ntry)
	ס	tor	Usual Residence of Decedent 10a. State		Jan.19,		MA 10d. Inside City Limits 1 □ Yes 2 □ No
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iteme 23a or 28a-f show enty injury or other traumatic event, the Medical Exam net must be notified at ODGs.	To Be Completed by Funeral Director	10e. Street and Number 9501 Woodland Drive 11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 □ No If Yes, Specify Cul 1 □ Yes 2 ☒ No If Yes, Specify	upation e during most of working eduction 18 ICIAN 18 Mother's Name Maria Ut est and Number or Rural and Avenue (ace) 1 Aug 1 Aug 1 Colling (ress of Facility Colling	USA city Yes or No- Rican, etc.) 16b. K Orch (First, Middle, Maider nknown (Route Number, City Pittsbu ate 20c. L 13 09 Silv ns Funera	or Town, State, Zingh, Pocation - City or Tower Spral Home	can Indian, etc. te dustry hony p Code) A 15221 fown, State ing, MD
68760,	Cate be executed /Medical bhysicien and supplysicien and supplysicien and supplysicien and supplysicien and supplysicien and supplysicien and supplysicients are supply	dicai Examiner	23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dy shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Cere or vosculor Due to (or as a consequence of): Current or vosculor Due to (or as a consequence of): Current or vosculor Due to (or as a consequence of):		respiratory arrest,		Approximate Interval Between Onset and Death
P.O. Box 6	The law requires that the death certifica tie has been signed by the attending phi page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	су		23d. Date of delik Month	very Day Year
	requires that t een signed by nould be detac	ted by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause g $\frac{D_{45}p_{80}}{2}$	given in Part I.		.,	the cause of death? obably 4 ∐Unknown
tal Rec	The la ate has page 2	e Completed by	25. Was case referred to medical	26. Place of Death	24a. Was an autopsy performed? 1 Yes 2 N	prior to death?	opsy findings available ompletion of cause of
Division of Vital Records,	Attending Phyer death. ector: After this by the funeral dis	Certification: To B	27. Manner of Death 1	other: 4 🖾 Nursing Hon ury at lork? □ Yes 2 □ No	ne 5 Residence 28d. Describe how input 28f. Location (Street a City or Town, Sta	iry occurred nd Number or Rui	
ā	Hospital or 24 hours afte Funeral Dir stely filled in b	Medical Cer	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the pass of examination and/or investigation, in my and manner stated.		and due to the cause(s) and manner as	
(1.1	Me		000333	> Au Reiste	ate signed (Month	
	Sta		Dontly Seay in 25 Main Street 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Suite 200	Keiste	istour, 1	10 21136
	Registi	ar	AUG 11 2009 Jeneur B. Jack				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. C 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 4:16 PM August 2009 Alderman 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Hospital Secours If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) N. CAROLINA 7. Age (In yrs. last birthday) Social Security Number 244-10-5362 1**X** M 2□ F Months Days Hours 91 MAY 31,1919 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 □ No BALTIMORE MARYLAND 10g. Citizen of What Country? 10e. Street and Number HPPLETON 10/2 N. 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 No If Yes, Give 7-30-4/3 Year or Dates: 1-30-4/3 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 Mo Specify Specify: BLACK 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) EMPLOYED SELF 9TH CRADE CEMENT FINISHER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ALDERMAN CARR ANNIE RUBERT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) IDIQ N. APPLETON ST., BALTIMORE, MD 21217 MARY B. ALDERMAN (LUIFE) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State CAPRISON FOREST CEMETERS 08/28/2009 OUSINGS MICLS, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD 21217 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)

Physician /Medical Examiner

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ending physician a use as the burial-

use

atter for u

signed by the a

cate has been si page 2 should b

certificate

Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific stely filled in by the funeral director,

within 24 hours a

Physician;

2

Completed

Be

Certification: To

Medical

The law requires that the death certificate be executed

P.O. Box 68760,

of Vital Records,

Division

Department of Important; If its any injury or o

Physician

Examiner

Funeral

Director

28a-f show

Director

Funeral

3

Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mantal Hygiene. and the fired at 7 is marked other than "natural", or items 23a or 28a-4 show any or other traumatic event, its "sected Event in traust to netition at

Baltimore, Maryland 21215-0036

/Medical

10a. State

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

	ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line.	Approximate Interval Between Onset and Death
_ a	metabolic acidosis	12-24 hours
	Due to (or as a consequence of):	
b	Due to (or as a construence of):	3-4 days
c.	dehydration	1-2 vecks
	Due to (or as a consequence of):	
d		

Examine Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery

23e. Did tobacco use contribute to the cause of death?

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

dementi

24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes

1 🗌 Yes

24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No

2 No 3 Probably 4 Unknown

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No

1 ☐ Yes 2 ☐ No 9 Unknown

> Hospital: 12 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28h Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Death (Check only one)

27. Manner of Death
1 Natural
2 Accident 3 Suicide

4 ☐ Homicide

5 Pending investigation 6 ☐ Could not be

determined

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier

29c. License number D66108

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore St. Baltimore, MD 21223 Dell Simmons 2000 31. Date filed (Month, Day, Year) 32.

State Registrar

AUG 26



DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-06568 State of Maryland / Department of Health and Mental Hygiene Robert Arbin Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month 0614 hrs August 22, 2009 Medical Examiner Robert William Arbin 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore University Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** oreian Months Hours Min Day Country) Maryland Director 212-98-2025 1X M 2 F 40 July 23, 1969 Yrs Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location any 10a. State 10b. County 1 Yes 2 X No 23a or 28a-f show notified at once. MD Harford Conowingo Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 63 Merry Knoll Lane 21918 USA 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 12. Was Decedent Ever in U.S. 11. Marital Status White, etc Armed Forces? 1 Never Married 2 X Married Yes 2 X No White Specify f Yes. Give Yea Yes 2 X No specify. Divorced Widowed 4 2 16a. Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Costco Wholesale traumatic event, the Medical Meat Cutter 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frances Schiminsky Robert William Arbin, Sr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ľvette Arbin, Spouse 63 Merry Knoll Lane-Conowingo, Maryland 21918 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place)
Highview Memorial 1 X Burial 2 Cremation 3 Removal from State Aug. 27, 2009 Fallston, Maryland Donation 5 Other Specify: -3 Newport Drive 21050 Forest Hill, Maryland 22. Name and Address of Facility Signature of Funeral Service Licensee Evans Funeral Chapel and Cremation Services Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Contact Gunshot Wound of Head Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical **AMENDED** UNPENDED attending physician or use as the burial The law requires that the death certificate be Box 68760 23d Date of delivery 23c. If ves, outcome of pregnancy IF FEMALE: Year 23b. Was decedent pregnant in the Month 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown detached for g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 V No 3 Probably 4 Unknown ģ Completed 24b. Were autopsy findings available 24a, Was an page 2 should рееп prior to completion of cause of autonsy performed? death? certificate has Yes 2 1 🗸 Yes No 26 Place of Death (Check only one) 25. Was case referred to medical the Hospital or Attending Physician: Division of Vital director æ Other; examiner? Hospital: 1 🗸 Inpatient 2 Other DOA Nursing Home 5 Residence 6 FR/Outpatient 3 · this ဂ 1 🗸 Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day,Year) FOUND: 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Subject shot self Certification: FOUND: 1 Natural Yes 2 V No n 24 hours after death.

e Funeral Director: /
etely filled in by the fu Pending Aug 21, 2009 1813 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 V Suicide Could not be or Town, State) 63 Merry Knoll Lane, Conowingo, MD (Specify) Single Family determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the 1 and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State

Registra

ORIGINAL

O.C.M.E

arke

111 Penn Street, Baltimore, MD 21201

August 24, 2009

30. Name and address of person who completed cause of death (Item 23a)

Donna M. Vincenti, MD

31. Date filed (Month, Day, Year)

Inch

Assistant Medical Examiner

32. Registrat's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month Physician 05:14 PM Tony Moorman Abbott Sr. AUGUST 19 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BALTIMORE 8. Date of Birth (Month, Day, Year) AGNES HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last bîrthday) 9. Birthplace (State or Foreign **Funeral** Virginia Hours Days 1**K**] M 2□ F Months 216-36-7208 70 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinat must be notified at 1 ▼ Yes 2 □ No Director Md. Baltimore 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 21225 409 East Patapsco Ave. U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 25 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Residential Builder 7th Carpenter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be Winford Abbott William Edna Velma Ridgell ဂ္ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Faye Abbott/spouse 409 East Patapsco Ave. Balto. Md. 21225 permit, Pages 1 and Department of Healt Important: If Item 27 any injury or other tonce. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park | 8/26/09 Glen Burnie Md. 4□Donation 5 ROther (Specify)entombment 22. Name and Address of Facility Gonce Funeral Service P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Hwy. Balto. Md. 21225 22a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIOMYOPATHY

Due to (or condition) Approximate Interval Between Onset and Death **Physician** 1 year /Medical Due to (or as a consequence of): **Examiner** DISEASE year CORONARY ARTERY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ COPD 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown has been si e 2 should b Completed DIABETES MELLITUS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an , page certificate 1 ☐ Yes 2 ☐ No 2 X No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 X Natural 5 Pending s after death.

I Director: All of in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number X. Ladnika, MD P22002 August, 19, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

AVENUE,

BALTIMORE,

21229

KALISETTI, 900 CATON

32. Registrar's Signature

31. Date filed (Month, Day, Year) _____

26

	_ 1	For State Registrar	11000	e Type or Pri State of M		d/b		nt of H	lealth and N	/lental Hy		0000	27265
Physiciar /Medica			Milton	BRANDT Sr.			Ah Cih	. Town o	Location of Doath	2. Date of De Month August	Day 20,		3. Time of Death 9:35 p. M
Examine Funeral Director		310 Came 5. Social Security N 213-18-	eo Drive 1umber 6		ge (In yrs. la			er 1 Year	Hagerstow If Under 24 Hrs. Hours Min.	m 8. Date of Bir Month, Da 07/25/		Washing 9. Bir	
he Maryland 28a-f show otified at	Director	Usual Residence of 10a. State MD 10e. Street and Nur	10b. County Anne	Arundel	10c. City	•	or Location	rnie	2		10c Cit	izen of What Co	10d. Inside City Limits 1 □Yes 2 ♠No
fter death v	runeral	343 Du 11. Marital Status 1 □ Never Marri	blin D	12. Was Decedent Armed Forces?	_{No} 194	3-		21 edent of H ecify Cubs	. 060 lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		U.S.	orican Indian, e, etc.
within 72 hours ene. than "natural",	Completed by	3 Widowed (Specific Specific	15. Decedent's cify only highest andary (0-12)	Year or Dates:	194	16a. [Decedent's Us 'Give kind of w life. DO NOT Pipe-	ork done use retired	during most of work d)	ing		ind of Business	nite /Industry poration
ould be filed via Mental Hyginarked other natic event, It	10 ae C	17. Father's Name	(First, Middle, La	ndt		T			18. Mother's Nam	Armswo	, Maiden orth	Surname)	
ges 1 and 2 should be the and the and the and the and the and the or other traum	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zity or Town, State, Z										2 2 Town, State		
109 KIVIETA DIIVE, TASA									e F sade	uneral	Home, PA D 21122		
Physician //Medical Examiner purial-transit	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):											Approximate Interval Between Onset and Death	
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the Machinal Certification: To Be Completed by Division Machinal	iysiciali/inedic	IF FEMALE: 23b. Was decedent in the past 12 1 □ Yes 2 [9 □ Unknown	months? ⊒No	23c. If yes, outcome 1 Live birth 4 Pregnant	2 Fetal	death	3 ☐ Ectopio 5 ☐ Other (у			23d. Date of de Month	livery Day Year
equires that is sen signed by ould be deta	2	Carcio	ne Crai	s contributing to death t	out not resu			cause giv	en in Part I.				o the cause of death?
sician: The law requir s certificate has been s irector, page 2 should		25. Was case refer							26. Place of Deat	1 □Yes	psy rmed? 2 140	prior to death?	utopsy findings available completion of cause of s 2 □No
ital or Attending Physicii rs after death. al Director: After this cer led in by the funeral direct	D :	examiner? 1 Yes 2 2 27. Manner of Deati 1 Natural 2 Accident	No :h 5	28a. Date of Inj (Month, Da	ury	28b. Ti	patient 3	28c. Injur Worl	er: 4 🗆 Nursing Ho		dence		ocityASSISTED LIVIN
lospital or Att		3 Suicide 4 Homicide 29a. Certifier (Check only	6 Could no determin	ad 28e. Place of in	of my knov	vledge,	death occurre	d at the ti	me, date and place	City or To	wn, State	a) and manner a	ural Route Number, us stated. e to the cause(s)
To the Hosp within 24 hou To the Fune Completely fill		one) 29b. Signature and	title of certifier	and manner si			2	9c. Licens		The district time,	29d. Da	te signed (Moni	th, Day, Year)
3 State Registrar		30. Name and addr VASAST 31. Date filed (Month	th, Day, Year)	A 340	m (LL Parks Signat	St	ype, Print) HA	8- M	18 217	46			

			ype or Print in Bl				•	
	•	1 - For State Registrar	State of Maryland	Certificate of		nental Hygler Reg. N	711 14	27266
Physici	an	1. Decedent's Name (First, Middle, Last)	ν Αθ !			2. Date of Death	Day Ye <i>a</i> r	3. Time of Death
/Medic Examin	al	4a. Facility Name (If not instruction, give st	BARTON	4b. Sity Town, o	r Location of Death	8	4c. County of Deat	3.15 P.M
LAMINI		getherda Hea	lt 4 Kelras	b Beth	esde		Rocken	le
Funeral Director		5. Social Security Number 6. Sex 125 24 3982	M 2 F 7. Age (In yrs. las	Yrs. Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birt 9. 9. Co	hplace (State or Foreign untry) unk
and		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location		1/ 1/		10d. Inside City Limits
a-f sho	ctor	MD Montgomer	в В	1 □Yes 2√€No				
with the a or 28 be not	Funeral Director	10e. Street and Number	Lit Haut	10f. Zip Code	0814	10g. (Citizen of What Co USA	untry?
death	neral	11. Marital Status unk 1:	2. Was Decedent Ever in U.S.	13. Was Decedent of H	Hispanic Origin? (Sp	pecify Yes or No-	14. Race - Ame	
s after or ite	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Year or Dates:	1 □Yes 2XINo	Specify:	Tricari, etc.)	Specify: wh	
72 hour		15. Decedent's Educa (Specify only highest grade	ation	16a. Decedent's Usual Occup (Give kind of work done			Kind of Business/	
within ene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired	d)	9		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If teem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Be	17. Father's Name (First, Middle, Last)	1	unk	18. Mother's Nam	e (First, Middle, Maid	en Surname)	unk
should and Me s mark umatic	To	19a. Informant's Name/Relationship (Typ	e. Print)	19b. Mailing Address (Street	and Number or Ru	ral Route Number, Cit	y or Town, State, 2	Zip Code)
1 and 2 Health a em 27 is		Bethesda Nursing 20a. Method of Disposition		5721 Grovsen	or Lane B		ID 20814 Location - City or	Town State
Pages nent of I		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☑ Other (Specify)	moval from State	ice of Disposition (Name of metery, crematory or other place	ce)	Date 200.	Location - City of	Town, State
permit. I Departm Importa any inju		21. Signature of Funeral Service Licenses Rona Let S		22. Name and Addre	ess of Facility Comy Board	l 655 W. Ba	 altimore	Street
202.00		23a. Rart 1. Enter the disease, or complic	ations that caused the death.	Baltimore, Do not enter the mode of dy	MD 2120 ng, such as cardiac	or respiratory arrest,		Approximate Interval Between
Physician		shock, or heart failure. List only one Immediate Cause (Final disease or condition	ASPIRATED	PNZUMONI	B			Onset and Death
/ /Medical Examiner		resulting in death)	Due to (or as a conseque		ccidena			2 Whs
pe sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	- 4-135		-		
execution and ial-trans	Examiner	that initiated events c. resulting in death) Last	Due to (or as a conseque	nce of):				
eath certificate be executed attending physician and for use as the burial-transit	- 1	€ d.						
n certific	n/Me	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregnand				23d. Date of del	ivery
that the death	Physician/Medica	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea 9 ☐ Unknown		су		Month	Day Year
The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	ρ	Part II. Other significant conditions cont	ributing to death but not result	ing in the underlying cause giv. $CTNN$	ven in Part I.			the cause of death?
e law req has beer	Completed	CANCER 0	LIME à Lu	ing mitusti	>6	24a. Was an autopsy	24b. Were au	utopsy findings available
			NGITIS	J		performed 1 □ Yes 2×2	? death? No 1 □ Yes	5
Physician: r this certific	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	ospital: 1 ☐ Inpatient 2 ☐ El	R/Outpatient 3 □ DOA Oth	ATT-	th <i>(Check only one)</i> ome 5 ☐ Residence	6 □Other (Spe	cifv)
ling Ph 1. After th funeral	ion:	27. Manner of Death 1 Statural 5 □ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of lnjury 28c. Injury Wor	ry at 'k?	28d. Describe how in		
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, factory, office]Yes 2□No	28f. Location (Street City or Town, St.	and Number or Ri	ural Route Number,
pital or ours afte eral Dir filled in			ician: To the best of my knowl	ladge, death occurred at the t	imo data and place			c stated
ne Hos n 24 hc ne Fun	Medical	(Check only one)	er: On the basis of examination and manner stated.	on and/or investigation, in my	opinion, death occu	rred at the time, date a	and place, and due	e to the cause(s)
To th To th	Ž	29b. Signature and title of certifier	Locas	29c. Licens	se number		Date signed (Mont	h, Day, Year)
		30. Name and address of person who con	npleted cause of death (Item 2		, 10-0		8/1	7101,
		TIP. MODAND. 31. Date filed (Month, Day, Year)	MD. 5530	O RISCONSIN	AVZ #	SEO CNR	M CHAS	F WD SCRIZ
Sta Registr	_	AUG 2 6 2009	32. Registrar's Signatu	parked				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Brown Avonnee thnettee A^{M} 25, 2009 12:27 August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE 8. Date of Birth (Month, Day, DS 24 Birthplace (State or Foreign Country) If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Funeral Hours Min 1 □ M 2 ★ F Months Davs 218.46.4511 PA**Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at Baltimore MD 1 ☐ Yes 2 No Director -Ochearr 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 20 Avenue ty Dutus Funeral [12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or I 1 ☐ Yes 2 No Specify. Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Good Shepherd Ctr 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental rivitte Barnes Burge 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samuel J. Brown Arbutuo Avenue Lochearn MD 21207 827 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Baltimore, MD 02/27/09 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address & Facility aughn (Greene Fun Fap Suco any. Vaughn C. 8728 Liberty Road Rundall Stown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ICHLE **Physician** 11telor disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner chest syndime Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner heart distate that initiated events resulting in death) Last to (or as a consequence of burial physician at the burial Physician/Medical attending p 38 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes has been a 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No 24a. Was an autopsy performed? Yes 2 No page certificate 1 □Yes Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this after death. I Director: After this of in by the funeral d 28a. Date of Injury (Month, Day, Year) 27. Manner of Dea h 1 X Natural 2 ☐ Accident 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 □ Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Declaration and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

To the Hospital o within 24 hours aft To the Funeral Di completely filled in Medical

Pages 1

be executed

law requires that the death certificate

Box 68760.

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Records,

of Vital

or Attending Physician:

Registrar

va

29a, Certifier

0059873

BaltimoreMD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

Charles St #203 6565 N. 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #5 per Fh g894 8/28/09 TT

State of Maryland / Department of Health and Mental Hygiene

	1 - For State of Marying	Certificate of Death	Reg. No.	
Physician/	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day	y Year 3. Time of Death
Medical		Bartholomew_		8, 2009 8:0/а м
Examiner	Gilchrist Center for Hospice	4b. City, Town, or Location of Death	wson 4c.	County of Death Baltimore
Funeral	5. Social Security Number. 6. Sex 7. Age (In vrs	s. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)
Director		62 Yrs. Months 53,5 Yes	Jun 1, 194	7 Maryland
and show tat		City, Town or Location		10d, Inside City Limits
he Maryland or 28a-f sho o notified at Director	Maryland N/A	Baltimore		1 ื Yes 2 🗆 No
21215-0036 within 72 hours after death with the Maryland giene. then "natural", or items 23a or 28a-f sho, the Medical Examiner must be notified at the Medical Examiner constitution of the Medical Examiner must be notified.	10e. Street and Number	10f. Zip Code 21216	10g. Cit	izen of What Country? U.S.A.
leath with the frems 23a cer must be	2725 Walbrook Avenue 11. Marital Status 12. Was Decedent Ever in		pecify Yes or No-	14. Race - American Indian,
36 ifter de amine	1 Never Married 2 Married 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puert	- 1	Black, White, etc. Specify: Black
ours a atural cal Exec	3 Widowed 4 Provoced Year or Dates.	16a, Decedent's Usual Occupation		ind of Business Industry
21215-0036 21215-0036 giene. crtan "natural". o the Medical Exam	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give kind of work done during most of work life. DO NOT use retired)	rking	Own Home
d 21; d 21; ed withi Hygiene other the ent, the		Homemaker		
and be filed be filed wreal Hy keed oth c event	17. Father's Name (First, Middle, Last) Charles Green Sr.	18. Mother's Na	me (First, Middle, Maiden : Annie E	
Maryland 2 should be filed 2 should be filed 7 ris marked out traumatic event To Be	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Ru	ıral Route Number, City or	Town, State, Zip Code)
e, Misand 2 sl Health a	Angela Roy	3407 Northway Drive Baltin	more, Maryland 21	1234
- 5 E C	1 ☐xBurial 2 ☐ Cremation 3 ☐ Removal from State	b. Place of Disposition (Name of cemetery, crematory or other place)		Dottimore Md
Baltimo permit, Page Department o Important: If any injury or	4 Donation 5 Other (Specify) 21. Signature of Juneral Service Loens	Loudon Park Cemetery 22. Name and Address of Facility	08/26/09	Baltimore, Md.
Bal	Though I Est	Estep Brothers Fur	eral Service, P. A	917
	23a. Part 1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line.	eath. Do not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
Ph sician/	Immediate Cause (Final disease or condition resulting in death)	estive Heart F	ailure	Onset and Death
Medical Examiner	Due to (or as a cons	quence of):		
<u> </u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	equence of;		
60 ate be executed bhysician and the burial-transit edical Examiner	Cause Disease or linjury that initiated events c.			
oe exe or	resulting in death) Last Due to (or as a conse	equence on:		
8760 ifficate be executed as the burial-transit	d			
P.O. Box 68760 P.O. Box 68760 s that the death certificate be e. gred by the attending physician be detached for use as the burit by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live Birth 2 ☐ F	gnancy Fetal death 3 Ectopic pregnancy	-	23d. Date of delivery
ivision of Vital Records, P.O. Box 68 or Attending Physician: The law requires that the death certificate has been signed by the attending in by the funeral director, page 2 should be detached for use a Certificate: To Be Completed by Physician/A	in the past 12 poinths? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of 9 ☐ Unknown 9 ☐ Unknown			Month Day Year
P.O. that the ned by the detach	Part II. Other significant conditions contributing to death but not	resulting in the underlying cause given in Part I.	23e. Did tobacco u	use contribute to the cause of death?
ds, F luires th an sign- uld be			1 □ Yes 2	□ No 3 □ Probably 4 □ Unknown
Records, The law requires cate has been signage 2 should b			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Re cate h			performed?	death?
Vital Reconsistant The law is certificate has the director, page 2 s	25. Was case referred to medical examiner? 1	26. Place of Death (Che	ck only one) Home 5 Residence 6	May 6 Gilchrist
of Virginia of Physical Physical Control of	T inpatient 2	28b. Time of 28c. Injury at	28d. Describe how injury	
ion tendin leath. cor: Aff the fur	1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation 3 Suicide 6 Could not be	M 1 ☐ Yes 2 ☐ No		
Division of tall or Attending P rs after cleath. all Director, After the din by the funera	4 Homicide determined 28e. Place of Injury - At building, etc. (Spec	home, farm, street, factory, office cify)	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,
Division of Vital Rec To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completed filled in by the funeral director, page Medical Certificate: To Be Com		owledge, death occured at the time, date and place,	and due to the cause(s) an	nd manner as stated.
The Fu		tion and/or investigation, in my opinion, death occurred my knowledge, death occurred at the time, date and pl	ace, and due to the cause(s	s) and manner as stated.
With Voters	29b. Signature and title of certifier	29c. License number	29d. Dat	te signed (Month, Day, Year)
	30. Name and address of person who completed cause of death (It	1 DQ0 10 T		118/2009
	Eric Bush MD 6701 1	Vicharles St. B	altimore	omb 21204
State Registrar	31. Date filed (Month, Day, Year) 32, Registrar's Sig	nature Arises		,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 23a per doc 8894 8-26-09 yt State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 340 PM AUGUST 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMOR If Under 1 Year If Under 24 Hrs. NA H05 P 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Months Days Hours Min. 1 □ M 2X F 68 Director 214-38-3095 8-31-1940 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinar must be notified at Director 1 Yes 2 No Baltimore MD N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with 21225 2861 Seamon Avenue USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2X Married 3altimore, Maryland 21215-0036 1 □Yes 2 No Specify: Black δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene.
7 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Disabled 10th grade N/A Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Hillary Smith Carrie Jackson ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Willie L. Burley-Husband 2861 Seamon Avenue Balto, MD 21225 20a. Method of Disposition Date 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cem 8-7-2009 Glen Burnie, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility March East F/H 21. Signature of Funeral Service Licensee 1101 E. North Avenue wan Balto, MD21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death bowe1 Immediate Cause (Final **Physician** to possible 2 Hour disease or condition resulting in death) ischemia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, farry, leading to influence cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a nonsinguisher of) To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown à s been signed b should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an scertificate has birector, page 2 sl autopsy performed 2 1 NO 1 ∐Yes 2 ₽No 1 Tes After this certific 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∏Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No hours after death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🖸 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2000 HOSF Day Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE 300 STAREL 32. Registrar's Signature 31. Date filed (Month. State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month 8 **Physician** 21 2009 6:00 Mary Banks /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 1700 N. Gay Street Apt 205 Balto If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕱 F Months Days Hours Min. Country 242-42-5038 Yrs 9-25-1922 Director N.C. 86 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It is Medical Examinations must be invited at 1 XYes 2 ☐ No Director N/A Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Gay Street Apt 205 21213 1700 N. by Funeral S A Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Maritai Status 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. Specify: Black 3€Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) A Elementary/Secondary (0-12) Private Homes Domestic 4th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mann Martin Fannie Ashley ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Highland Spring, VA 23075 401 Renee Court Roseline Taylor-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garden of Faith 8-26-2009 Balto Co, MD 22. Name and Address of Facility March East F/H 21. Signature of Funeral Service Licensee 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed Exami and burjal-trar Due to (or as a consequence of): Box 68760, physician Physician/Medical the as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) signed by the a P.0. 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ has been si e 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform page certificate 2 No 1 ☐Yes → Dio 1 ☐ Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No this Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 28d. Describe how injury occurred Division Hospital or Attending 1 Natural
2 ☐ Accident 5 Pending Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. М Investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

orleans

eted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

		for State Registrar 1. Decedent's Name		State of Ma 21 per fl	arylano / 1, g894 ,	08/2 08/2	6/09dhb tificate of	Deati		2. Date of De		2009	2 1 2 1 1 3. Time of Death
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	dical niner		_	e street and number)			4b. City, Town,		n of Death			County of Death	
Funer		5. Social Security Nu 218–20–5	ımber 6. S	Sex 7. Ag	e (In yrs. last l 34	birthday) Yrs.	If Under 1 Year Months Days	If Und	er 24 Hrs. Min.	8. Date of Bir (Month, Da 12/06/	th ly, Year 1924		place (State or Foreign ntry)
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Maryla f shor	ţō	MD	Balti	more	Too. City, 10		edale						1 □ Yes 2 X No
with the la or 28a	I Direc	10e. Street and Num					10f. Zip Code 21237	7			10g. C	itizen of What Cou	ntry?
idryiding ZIZIS-UUSO 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, fir Middeal Estimer must be confined a	by Funeral Director	11. Marital Status 1 Never Marrie 3 Widowed 4		12. Was Decedent Armed Forces? 1	Ever in U.S.		Mas Decedent of fYes, specify Cu I □Yes 2X No			cify Yes or No Rican, etc.)	-	14. Race - Ameri Black, White, Specify: Wh:	etc.
5-0050 72 hours aff natural", or	Completed	(Specif	Elementary/Secondary (0-12) College (1-4or 5+)					upation e during m	ost of workin	g	16b. k	Kind of Business/In	dustry
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re, Marylia s 1 and 2 should if Health and Mer Item 27 is marke other traumatic	2	19a. Informant's Nar				g Address (Stree					or Town, State, Zi,	p Code)	
Dallinofe, Ma permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra				Removal from State	20b. Place ceme Park	of Dispostery, cren	sition (Name of natory or other pla Cemeter	a <i>c</i> e)	08/12	/2009		ocation - City or To	
permit. Departr Importa	once.	21. Signature of Fun	neral Service Lice her Lass		DVR	122 L 7	. Name and Add assahn 1 401 Bela	ress of Fed Junera	al Homo	e Inc. Baltimo	re.	MD 21236	5
Physicial Physician and By Street Physician and By Street Physician and By Street Physician as the purial-transit	al	Immediate Cause (F disease or condition resulting in death) Sequentially list condif any, leading to immediate. Enter Underlicause. Enter Underlicause (Disease or in that initiated events resulting in death) Leading to the condition of the con	ditions, nediate lying njury	b. Due to (or as	a consequence a consequence a consequence	e of): e of):	ailure						Onset and Death 4 years
ath cer attendin for use	ian/M	IF FEMALE: 23b. Was decedent p in the past 12 m 1 □ Yes 2 □ g □ Unknown	nonths?	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal dea		Ectopic pregnar	псу				23d. Date of delive Month	very Day Year
uires that is signed by Id be deta	d by Ph			contributing to death be	ut not resulting	in the ur	nderlying cause g	iven in Par	rt I.	23e. Did 1	,	7	the cause of death?
To the Hospital or Attending Physician: The law requires that the de within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Completed									24a. Was auto perfo		24b. Were autresprior to condeath?	opsy findings available ompletion of cause of
VILA Iclan: Sertific ector, I	Be C	25. Was case referre examiner?		Hoorital						(Check only o	one)		
dlng Phys h. After this	ion: To	1 Yes 2 N N 27. Manner of Death 1 N Natural	5 Pending investigation	28a. Date of Inju (Month, Da	ent 2 ER/0 lry 28b y, Year)	Outpatien Time of Injury	28c. inj Wo		2	ne 5 Resi 8d. Describe		6 ☐ Other (Specury occurred	ify)
lor Attendate after death Director:	Certification:	2 Accident 3 Suicide 4 Homicide	6 Could not b		ury - At home, c. <i>(Specify)</i>	farm, stre	eet, factory, office			8f. Location (Street a wn, Stai	and Number or Rui te)	al Route Number,
e Hospita 24 hours e Funeral	edical C	29a. Certifier (Check only one)	Certifying Pi	nysician: To the best niner: On the basis of and mapher sta	f examination	ige, death and/or in	n occurred at the vestigation, in my	time, date opinion, d	and place, a death occurre	and due to the ed at the time,	cause((s) and manner as	stated. to the cause(s)
	Me	29b. Signature and	Itle of certifier	Dr	_			nse numbe 1149	er		29d. D	ate signed (Month	1 (Car) 4
25+1)	30. Name and address Hector Si		completed cause of d				owson	, MD 2	21204		/	
Regi	State strar	31. Date filed (Month	n, Day, Year)		ar's Signature	1.							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Dorothy Elizabeth Beauchamp 45AM 20x /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Arno1d Future Care Anne Arundel Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day,) Aug. 13, 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Months Hours Year Days 1 □ M 2 🕱 F 89 218-09-2448 Director 1920 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ∏Yes 21 TtNo Director Md. Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 358 Phirne Road 21061 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married more, Maryland 21215-0036 1 ☐ Yes 2XXNo ģ Specify: White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) 10th College (1-4or 5+) Check Clerk Federal Reserve Bank .. Pages 1 and 2 should be filed wi tment of Health and Mental Hygier tant: If item 27 is marked other th jury or other traumatic event, Ing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Matthew Martin Hogan Anna Eigeldinger ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any Injury or other trau Irene Toney / Daughter 358 Phirne Rd. Glen Burnie Md. 21061 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkwood Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 8/21/09 Balto. Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service P.A. 21. Signature of Funeral Service Licensee monumanth 4001 Ritchie Hwy. Balto. Md. 21225 Mome 23a. part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician DEMENTI /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): il or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 Yes 2 No detached 9 Unknown signed by d Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ PlanystaTHY 3 Probably 4 Unknown 2 No Completed AMIODARONE HERATITIS 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Landursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide e Funeral I 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier To the Hozy within 24 hor To the Fune completely fi (Check only one) and manner stated. 29b. Signature and title of certifier

171

State Registrar MUL

Date filed (Month, Day,

Year

204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

60

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month AUG 0410AM BARRY JOHN 2009 20 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death HOWARD COLUMBIA HOWARD COUNTY GENERAL HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye. March 28, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 3. 1945 1 X M 2 □ F Nevada 64 214-42-3447 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 □ No Rockville Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20851 United States 1617 Lewis Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 M Married 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Trucking Truck Driver 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jean E. Harrison James Barry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1617 Lewis Avenue, Rockville, Maryland 20851 Frances C. Barry / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition August 25, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park Rockville, Maryland 4 Donation 5 Dother (Specify) 2009 21. Signature of Fundal Pervice Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 M01305 Approximate Interval Between Onset and Death 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) da phc Due to (or s a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter thirderlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 3 Ectopic pregnancy Year 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy memana 1 ☐ Yes 2 ☐ No 1 □Yes 5. Was case referred to m → cal examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 1 Residence 6 \(\text{Other} \) Other (Specify) 1 tnpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Director

Funeral

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Completed

Be

2

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Box 68760.

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Division of Vital Records,

Exami Physician/Medical

ρ Completed

attending physician for use as the buria signed by the a d be detached f After this certificate

burial-transit and certificate be within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p or Attending

Be

Certification: To

Medical

Hospital

State Registrar

1 165 Z	0
Manner of Death	
1 ☑ Natural	5 Pending
2 Accident	investigation

3 Suicide 4 - Homicide

29a. Certifier

(Check only one)

29b. Signature and hile of certifier

6 Could not be

28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

28c.

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

MD, FCCP	14	D,	FCC	P
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and manner stated.

29c. License number 936845 29d. Date signed (Month, Day, Year)

30. Name and advess of person who completed cause of death (Item 23a) (Type, Print) Man - Clin 50 0 mive Cot

31. Date filed (Month, Day, Year) 6

Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 27274

Bryan Montgome		urken - For State	Sta	ate of Maryla	and / Dep Ce	artment of ertificate of	Healt Deatl	h and h	Menta	al Hygie		2 a. No.	009 2	727
Physicia	_	Registrar 1. Decedent's Name	(First, Middle	e,Last)			Dout	<u> </u>			late of Death		3. Time of Death	
Medical Examin	er		BRYAN			BURK				A	ugust 22,	2009 4c. County of De	1011 hrs	
*	П	4a. Facility Name (if		n, give street and n w William Land		4b. City, Town, or Location			ocation of	ation of Death		Anne Aruno		Ì
Funeral	-	5. Social Security N		6. Sex		. last birthday)				24Hrs. 8.				
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or 28	Director	2219 SUG		ROAD				2120	9			USA		
r death with the Maryland or items 23a or 28a-f show must be notified at once.		11. Marital Status		12. Was De	cedent Ever in			ent of Hisp	anic Origin		y Yes or No-		merican Indian, Black,	
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imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatte event, the Mc thal Examiner must be notified at once	m I	MITC 19a. Informant's Na		hip (Type, Print)		BURKEN 19b. Mailir	ng Addres	s (Stree			I Route Nur	nber, City or Town,	State, Zip Code)	
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Division of Vital Records, P.C ral or Attending Physician: The law requires that its after death. al Director: After this certificate has been signed the in by the funeral director, page 2 should be detailed in by the funeral director, page 2 should be detail.	Completed				_						24a. Was	psy pr	ere autopsy findings a for to completion of ca	vailable use of
ecol he law ate has age 2 sl	dwo												eath? ✔ Yes 2	No
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F Vit	To E	1 🗸 Yes	2 No	Hospital: 1	Inpatient 2	ER/Outpatie		DOA	Other			Residence 6 V		
n of ding Ph. h. After t		27, Manner of Dea		nding FOU	ate of Injury onth, Day,Year) ND:	FOUND:	n injury		Yes 2	. Is		nped from Bay		
ivisior or Attend after death Director:	icat	2 Accident 3 Suicide	Inv	estigation Aug 2	22, 2009 lace of Injury	1011 hrs At home, farm, st	reet, facto	ry, office	building, e	tc. 2			r or Rural Route Numb	er, City
Div Hospital or 24 hours aft Funeral Di	Certification:	3 Suicide 4 Homicide	det	ermined (Spec		Road / Highwa						ton Lane Jr. Men	norial Bridge, Annar	oolis, MD
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b		29a. Certifier (Check only one)	Certifying I	Physician: To the	best of my know	wledge, death occ	curred at t	he time, o	iate and pl	ace, and d	ue to the car	use(s) and manner te and place, and du	as stated. ue to the cause(s)	
To the within 2 To the Complet	Medical	29b. Signature an		and manne	er stated.	S. I GITO/OF ITIVESU			se number				ed (Month, Day, Year)	
	_		() 1	11				.M.E.			August 23,	2009	
		30. Name and add	iress of perso	m who completed o	ause of death									
		Jack Titus	MD. De	puty Chief Me					Itimore,	MD 212	201			
S Regis	tate trai		AUG 2	6 2009 32	Registrar's Sig	gnature A.	park	4						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** August 24, 2009 1:15 a. M Albina M. Caputo /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Nursing Home Montgomery Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea July 18, 1 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min 1 ■ M 2 🖳 F 93 203-01-2667 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a, State 10b. County MD Rockville Montgomery 1 ☐ Yes 2X No Funeral Director iled within 72 hours after death with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code a or ms 23a 303 Adclare Road 20850 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2x No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes \$ No Specify: White Specify Completed by 3√ElWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical Elementary/Secondary (0-12) College (1-4or 5+) 12Sales Clerk Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) id 2 should be fill the and Mental H 27 is marked ott traumatic even Be John Molinaro Mary Angela Moore 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11112 Way Cross Way; Kensington, MD 20895 Health tem 27 i Maria C. Weiss, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Department of Important: If it any Injury or o oonce. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/29/2009 Cathedral Cemetery Scranton, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Dicens 22. Name and Address of Facility Rapp Funeral & Cremation Svcs. V 933 Gist Ave. Silver Spring, MD 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Chronic Renal Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hypertensive Heart Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner burial-transi Dementia that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Box 68760. Physician/Medical as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy o in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🗚 🗷 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4XX Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred e Hospital or Attending P 24 hours after death. e Funeral Director; After t letely filled in by the funera After 5 Pending investigation Natural 1 Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled in a second completely filled in the second completely fill 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier August 24, 2009 D0047330 JOHN Womas 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas V. Joseph MD; 50 W Edmonston Dr. Ste. 207 Rockville, MD 20852 31. Date filed (Month, Day, Year) State AUG 26 2009 and Registrar

09-05825 Roberto Carlos Ce	dill	Please Type or Print in Black Indelible Ink. Ensure All Copie	s Are Legib ⁄giene	ole.	09 2727
Roberto Carlos Ce	1.	For State Amend Item 201 per me, go Financial Continuation of Death	Reg. N		
Physician	1	. Decedent's Name (First, Middle,Last)	2. Date of Death Month Da	y Year	3. Time of Death 1730 hrs
Medical Examine		Roberto Carlos Cedillo a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	July 25, 2009	4c. County of Deat	1
	4	Prince George's Hospital Center Cheverly		Prince Georg	
Funeral Director		Social Security Number 11 6 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 30 Yrs.		/M/DD/YYYY) 9. Bi Forei 1978 Co	thplace (State or gnunk buntry)
any	-	Usual Residence of Decedent			10d. Inside City Limits
	١,	4D Prince Georges Hyattsville			1 Yes 2 X No
ith the Maryland 23a or 28a-f show notified at once.	탏	10e. Street and Number 10f. Zip Code	_	Citizen of What Cou	intry?
th the N		S12/ 15th Avenue	pecify Yes or No-	14. Race - Ame	rican Indian, Black,
ath wit items?	Funeral	1 Never Married 2 Married Armed Forces? unk If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	
ifter de		3 Widowed 4 Divorced If Yes, Give Year 1 X Yes 2 No specify:	The second second	Specify: his	
hours a	ed by	15. Decedent's Education (Specify only injenset grade completed) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret		ob. Kind of business	Anidustry Cliff.
36 iin 72 l ihan "-	Bet	Elementary/Secondary (0-12) College (1-4 or 5+) unk unk			
5-00 ed with fygiene other	Completed	17. Father's Name (First, Middle, Last) unk 18.Mother's Nam	e (First, Middle, Mai	iden Surname) ut	ık
21; be fill mital F riked	å	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or	Rural Route Number	er, City or Town, Sta	te, Zip Code)
ID 2 should and M 7 is m	ို	O.C.M.E. 111 Penn Street; Balt	imore, Ma	aryland 2	1201
e, M I and 2 Health item 2	ł	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City	or Town, State
mor Pages ent of nut: If		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 X Other Specify: in State			
Saltii rmit. epartm nporta		21. Signature of Funeral Service Licensee Daylor Cator 25 name and Adulational Boa	rd; 655 V	V. Baltim	ore Street
	_	Baltimore, Mary Is	or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
Physician i al		failure. List only one cause on each line. Immediate Caus. Final disease a. Multiple Injuries			Death
.aminer		or condition resulting in death) Due to (or as a consequence of):			
	-a	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	lical Examine	(Disease or injury that initiated		<u> </u>	-
ecuted and - transit		events resulting in death) Last Due to (or as a consequence or). d.			
e execute cian and rial - tra		UNPENDED AMENDED			
Sion of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed death and death. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - transi	Physician/Medic	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic preg	nancy	23d. Date of deli	Pery Day Year
x 68 th certification tending	iciar	past 12 months? 4 Pregnant at time of death 5 Other (Specify)		2	
Box he death of the atternay the atternay the deforus	hys	1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tot	pacco use contribute	e to the cause of death?
;, P.O. Beires that the designed by the	þ	rait ii. Other Significant Contaction Community	1 Yes	2 🗸 No 3 🔝	
cords, law require has been si, 2 should b	Completed		24a. Was a autops	sy prior	e autopsy findings available to completion of cause of
Records, The law requir ficate has been s	dmo		perform 1 V Yes 2		
tal Rection: The certificate	a)	25. Was case referred to medical examiner? Hospital: A lengtion 2 FR/Outnatient 3 DOA Other Nut		D	other:
of Vital ing Physician After this certi	To B	1 V Yes 2 No Inpatent 2 Elevation of Mark 2	5g , 15	Residence 6 C	ntrei .
n of ding Ph	on:	1 Natural 5 Pending FOUND: 1 Yes 2 No	Pedestrian s	struck by auto	
Division rate and Division and Director:	Certification:	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (S	Street and Number of tate) Prince	r Rural Route Number, City
Div Div Ours aft	erti	determined (Specify) Major Road / Highway	Manboro Pike	, , , , , , ,	tyrrice decigos es, ma
Division Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only one) 29a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, to the death occurred at the date at the date and the death occurred at the date at	and due to the caus ed at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
To th withir To th comp	Medical	29b. Signature and title of certifier 29c. License number 29c. License number			(Month, Day, Year)
	2	O.C.M.E.		July 26, 2009	
		30. Name and address of person who completed cause of death (Item 23a)	ID 04004		
		Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, N	21201 בו		
S Regis	tate tra				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 65 09:11 2009 AUG /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SINAL HOSPITH OF BALTIMORE BALTIMORE ary 8. Date of Birth (Month, Day, 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday Year) Months Days 1 ☐ M 2 🛛 F Hours 218-48-011 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ¶ZYes 2□No 171110 10e. Street and Number 10f Zip Code 10g, Citizen of What Country? 21216 by Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. 14 Bace - American Indian 1 Never Married 2 Married 1 □Yes 2 No Blac Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ardenne DWINGS Mills Verne 10011 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland 21. Signate) e of Funeral Service Licensee Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 2 days Septic Shock disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year . □ Yes 2 No 9 □ Unknown 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? à reluic hemotomo 1 Yes 2 No 3 Probably 4 Unknown Be Completed Neurosarcoidosis Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Cardianyopath 1 □ Yes 2 210 2 1 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide ☐ Could not be

requires that the death certificate be executed and Box 68760 physician attending ō O. been signed by the should be detached ۵. Records, has page 2 certificate Vital ō

Funeral

Director

show

ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at

is marked other than

permit. Pages 1 and 2:
Department of Health a
Important: If Item 27 is
any injury or other trau

Physician

/Medical

Examiner

Perse!

Maryland 21215-0036

Baltimore,

Physician: After Division Hospital or Attending death. after death Director: completely filled in by 124 hours a within 2 To the I To the

131	

Medical

KOSAS-CARDERON MBBS 31. Date filed (Month, Day, Year) State

of certifie

determined

4 Homicide

(Check only one)

29b. Signature and Itle

29a. Certifier

SINA MOSPITAL OF BALTIMORE

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature AUG 2 6 2009

MBBS

Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RES-000

28f. Location (Street and Number or Rural Route Number, City or Town, State)

AUG 22 2009

29d. Date signed (Month, Day, Year)

09-06590 Mary B. Collin

Phys Medical Exa

06590 y B. Collins			or Print in Black In						ible.		
		1- For State Registrar	Cer	tificate c	of Deat	h		Rec	. No.	200	0 2727
Physicia dical Examin	n/	Decedent's Name (First, Middle,La Mary B.	collins					2. Date of Death Month August 22,		Year	3. Time of Death 1915 hrs
		4a. Facility Name (if not institution, gi			4b. City, 7	Town, or Lo	ocation of Dear			unty of Death	
	ı	Baltimore Washington Me	edical Center		Glen	Burnie			Ann	e Arundel	
Funeral Director		5. Social Security Number 6. S 220-46-3260 1	Sex 7. Age (In yrs. Ia	ast birthday) 59 Yi	Month	er 1 Year s Days	If Under 24Hi Hours Mi	n.	0/194	Foreig	hplace (State or n untry) MD
ryland a-f show any <u>t once.</u>	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Anne A 10e. Street and Number		Town or Loca			Burnie	10	a. Citizen	of What Coun	10d. Inside City Limits 1 Yes 2 X No
th the Ma 23a or 28 10tified a		123 Glen Road				2	21060			USA	,
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at once.	Fune	11. Marital Status 1 Never Married 2 X Marrie 3 Widowed 4 Divorce	12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 X No If Yes, Give Year		Yes, specif		Mexican, Puer	Specify Yes or No- to Rican, etc.)		White, etc.	can Indian, Black, nite
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural"; c event, the Medical Examiner	eted by	15. Decedent's Education (Specify of Elementary/Secondary (0-12)	or Dates:		ent's Usual	Occupatio	n (Give kind of OO NOT use re			of Business/li	ndustry
21215-0036 nuld be filed within 7 Mental Hygiene, marked other than c event, the Medica	Completed	12	t)		Beaut			ne (First, Middle, M		air Dre	essing
1215 d be filed lental Hy arked of	Be	Earl Newsome					Mary	D. Gra	achik		
MD 2 12 shoul th and M 127 is m umatic e	욘	19a. Informant's Name/Relationship (Donald J. Collin		7	_	•		Rural Route Numl	-		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medica		20a. Method of Disposition 1 Burial 2 X Cremation 3	Removal from State	Place of Dispo crematory or o	osition (Nar other place	ne of ceme	etery, Au	Date 1g. 26	20c. Loca	ation - City or	Town, State
Baltin permit. P Departme Importan	Ī	4 Donation 5 Other Specification of Funeral Service Lice		tro Cr	. Name and	Address	of Facility		s Fun	eral H	Maryland ome, P.A.
Physician	1	23a. Part I. Enter the disease, or com	aplications that caused the death.	Do not enter				Road, Pas			21122 Approximate Interval
/Medical xaminer		failure. List only one cause of a Immediate Cause (Final disease or condition resulting in death)	each line. Multiple Injuries Due to (or as a consequence of	F):							Between Onset and Death
	Jer	Sequentially list conditions, If any, leading to immediate Due to (or as a consequence of):									
	xaminer	cause. Enter Underlying Cause (Disease or injury that imitated events resulting in death) Last Due to (or as a consequence of):								1	
execul an and al - tra	dical	UNPENDED	v	.nerFH	I. G894	.8/2	6/09.WS				
Records, P.O. Box 68760, The law requires that the death certificate be excate has been signed by the attending physician page 2 should be detached for use as the burial	sician/I	UNPENDED AMENDED Item#19b, perFH, G894, 8/26/09, WS IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1									
P.O. B	2	Part II. Other significant conditions	contributing to death but not re	esulting in the	e underlying	j cause giv	en in Part I.				the cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rest after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Completed							24a. Was a autops perform	med?		topsy findings available completion of cause of
m: T		25. Was case referred to medical				26.Place o	of Death (Chec			. 💆	
Vital F hysician: this certifi al director,	Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatie	nt 3 C	OOA C	ther Nurs	sing Home 5 1	Residence	e 6 Other	**
Division of Vital I the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certifingletely filled in by the funeral director.		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year) Aug 22, 2009	28b. Time of 1854 hrs	f Injury	28c. Injury	at Work? es 2 🗸 No	28d. Describe h Pedestrian s			
Division ital or Attencurs after death ral Director:	ertification:	2 Accident Investiga 3 Suicide 6 Could no determine	t be 28e. Place of Injury - At ho		reet, factory	, office bu	ilding, etc.	28f. Location (S or Town, St B & A Blvd/Oa	ate)		ral Route Number, City
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	등	29a. Certifier (Check only 1 Certifying Physic	cian: To the best of my knowledger: On the basis of examination at and manner stated.	ge, death occ				nd due to the cause	e(s) and m	nanner as state	
To To	울ㅏ	29b. Signature and title of certifier	and manifol stated.		29	c. License	number		29d. Dat	e signed (Mo	nth, Day, Year)

within 24 hours after death.

State Registra

DHMH 17 Rev 1/2001

OCME 2006

Margarita Korell MD

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

August 23, 2009

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Lineage-park Name (Park, Madin, Last) Lineage-park, Name (Park, Madin, Last) Lineage-park, Name (Park, Madin, Last) Li	ryland அது நகுந்து நிக்கி ealth and Mental Hygiene Certificate of Death Reg. No. 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	Cer	em T per d	Amend Ite	1 - State Registrar	-									
A Facility Name: (if not instantation; gave arrivar and number) Shaddy Grove Hospital A Facility Name: (if not instantation; gave arrivar and number) Shaddy Grove Hospital A Facility Name: (if not instantation) A Facility Name: (i	k Cheung Chang 2. Date of Death Month Day Year 3. Time of Deat	Cheung					Physicia								
Shady Grove Hospital Fundamental Control Control					4a Facility Name	al	/Medic	٠							
Second Security Number Second						er	Examine)							
Top Street and Partners Top Cartiny To				-9563 ¹ 2	107-46-										
Elementary/Secondary (0-12) College (1-4or 5-) Chef Restaurant	10c. City, Town or Location 10d. Inside City Lin	Oc. City, Town or Loc		10b. County	10a. State	l h	MO #	land							
Company Content Cont	Gaithersburg 172 Yes 2		mery	Montgo	MD	ctor	3a-f sh	Man							
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Elementary/Secondary (0-12) College (1-4or 5-) Chef Restaurant	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc.	If	Armed Forces? 1 Yes 2 N If Yes, Give		1 Never Mar	by	al", or Items	036 urs after dea							
Physician / Medical Examiner Physic	(Give kind of work done during most of working	(Give k	ade completed)	condary (0-12)		mpleted	ne. han "natur e Medical.	1215-U rithin 72 ho							
Physician / Medical Examiner Physic)		17. Father's Name	S .	d 21;								
Physician / Medical Examiner Program of the part of t	unkn. unk	u					Mental irked c	land land be fill hental H rked oth							
Physician / Medical Examiner Physic		1					h and l	Mar)							
Physician / Medical Examiner Physic	20b. Place of Disposition (Name of Date 20c. Location - City or Town, State	20b. Place of Disposi	ng / wire			-	Healtl tem 27 other t	. 1 and							
Physician / Medical Examiner Physic	St. Raymond Cemetery 8/22/2009 Bronx, NY	St. Raymon	fy)	5 ☐ Other (Specify	4 ☐ Donation		rtment or rtant: If I	timo t. Pages							
Physician Modical Examiner Physician Modical Examiner Section Physician Modical Examiner Physi	Charles L. Stevens Funeral Home Inc.	rshall 22.	Mand	outo V	21. Signature of F	1	Depa lmpo any l	ש בו							
Cause (lighest each of the standard of the sta	he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Myocardial Infarction consequence of): DSClerotic Coronary Artery Disease Approximate Interval Between Onset and Death minutes years	Myocardial consequence of):	a. Acute Due to (or as a	eart failure. List only of (Final ion)	shock, or hea Immediate Cause disease or condition resulting in death)	-	/Medical Examiner								
FFEMALE: 23b. Was deedednt pregnant in the past 12 months? 1 1 1 1 1 1 1 1 1		, , , , , , , , , , , , , , , , , , , ,	c	or injury ts	that initiated events	Exam	sician and burial-transit	5U , be executed							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of the ca			d			ledic		-							
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25. Was case referred to medical examiner? The property of	not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death	not resulting in the und	contributing to death but	ificant conditions co	Part II. Other signi	by	be d	The The sage							
Signature and title of certifier 28e. Place of injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Num 28f. Location (Street and Number or Rural	autopsy prior to completion of cause performed? death?						ate h								
Solution of the part of the pa	Other	2 TSTER/Outpatient	Hospital:		examiner?	m	s certif	VII.							
	(Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred	28b. Time of	28a. Date of Injury (Month, Day,	th 5 ☐ Pending	27. Manner of Deat	⊢ ⊪	th. : After thi e funeral c	On OI							
	y - At home, farm, street, factory, office (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	- At home, farm, stree (Specify)	e 28e. Place of injur building, etc.		3 ☐ Suicide	Sertifica	s after dea	DIVIS alor Atte							
	examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	xamination and/or inve	niner: On the basis of	Certifying Phy 2 Medical Exam	(Check only		in 24 hour	he Hospit							
1000000	29c. License number 29d. Date signed (Month, Day, Year) DOOTS 8025 August 9 2009	en mi	rand	d title of certifier	29b. Signature and	Σ	with To t	Tot							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johnathan Wenk, M.D. 9901 Medical Center Drive, Rockville, MD 20850						;									
State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 20 2009 AUG 20 2009 AUG 20 2009	's Signature	Signature	32. Registrar	nth, Day, Year)	31. Date filed (Mor										

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Madical Evantina Lusis be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, 10 St Regist

	Registrar					runcate or	Deain		Re	g. No U	0	4_ / L	_ 0 0
an	1. Decedent's Name	e (First, Midd		ernardi	Cross	3			Date of Death Month ugust	Day	Year 009	3. Time o	
cal ier	4a. Facility Name (I	f not institutio	n, give street and n	umber)		4b. City, Town,	or Location of	Death		4c. County	y of Death	1	
	Montgome	ery Vil	lage Heal	lth Care	9	Montg	omery '	Villa	ge	Mont	gomer	y	
	5. Social Security N		6. Sex	7. Age (In yrs.			If Under 2	4 Hrs. 8.	Date of Birth	Year)	9. Birth	nplace (State intry)	or Foreign
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ne	11. Marital Status		12. Was De	cedent Ever in U	l.S. 13.	Was Decedent of If Yes, specify Cul	Hispanic Origi	in? (Specify Puerto Rica	y Yes or No- an. etc.)		ce - Ameri	ican Indian,	
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Be Completed by Funeral Director	Elementary/Seco	ndary (0-12)	College	(1-4or 5+)	(Give kind of work done during most of working life. DO NOT use retired)					Own 1	Uomo		
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Be	17. Father's Name				18. Mother's Name (Fir					aluen Samai	110)		
2		Bernar			Leah Egan 19b. Mailing Address (Street and Number or Rural Route Number,								
	19a. Informant's Na			h + o						er, City or Town, State, Zip Code) Esburg, Maryland 20879			
	Teresa M.		on / Daug.					Date		Oc. Location			20073
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	4 ☐ Donation			Gat		aven Cemete		2009		Silver S		•	ina
	21. Signature of Fu	ineral Service	Licensee	MC	Range Range	22. Name and Addi Dert A. Pu	ess of Facility mphre y F	uneral	Home/R	ockville	e, Inc		0005
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	23a. Part 1/Enter to shoot, or hea	he dis <i>e</i> ase, o irt failure. Lis	r complications that t only one cause on	caused the dea each line.	th. Do not er	nter the mode of dy	ring, such as c	cardiac or re	espiratory arre	est,		Approxima Interval Be Onset and	etween Death
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n/Medical Examiner				(0) 40 4 001100	400,100 0.7.								
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ysic	1 ☐ Yes 2 ☐ 9 ☐ Unknown		9 🗆 Un		00411 0	other (opcomy)							
Completed by Physicia	Part II. Other signif	ficant condit	ions contributing to	death but not re	sulting in the	underlying cause g	iven in Part I.		23e. Did tob	acco use cor	ntribute to	the cause of	death?
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io	1 🔀 Natural	5 Pendi		e of Injury onth, Day, Year)	Injury	We	ork? ⊡Yes 2.∐.N		a. Describe no	w injury occu	IIICG		
icat	2 ☐ Accident 3 ☐ Suicide	6 Could	not be 28e Pla	re of Injury - At h	nome farm s				. Location (St	reet and Num	nher or Bu	ıral Boute Nu	mber.
Ĭ.	4 Homicide	deterr	mined 206. Flat	ding, etc. (Spec	ify)	treet, factory, office		20	City or Town	, State)	1001 01 110		
Ö	29a. Certifier	1 Certify	Ing Physician: To t	he hest of my kn	owledge dea	ath occurred at the	time, date and	d place, and	d due to the c	ause(s) and r	manner as	stated.	
Medical Certification: To	(Check only one)		i Examiner: On the										(s)
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	30. Name and addr	ress of person			m 23a) /Tvno								
	Sherin A					lar Drive	, #206	, Rocl	kville	. Marv	land	20850	
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rar		ALIC O	6 2000	Registrar's Sign	A. 14	arked							
1001		AUG &	n CARA I You	RATIO	/ //								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State of Maryland / Department - State of Maryland / Department - Certifica	te of Death	Reg. N	0000 07001
	Physici		1. Decedent's Name (First, Middle, Last) ROSLYN COHN		2. Date of Death Month AUGUST 2	22 2009 3. Time of Death
.7	/Medic Examir		4a. Facility Name (If not institution, give street and number) 4b. City	, Town, or Location of Death		ic. County of Death BALTIMORE
	Funeral		5. Social Security Number 6. Sex v 7. Age (In yrs. last birthday) If Under	ANDALLSTOWN or 1 Year If Under 24 Hrs.	8. Date of Birth	
	Director		216-03-4973 Output Security Number 216-03-4973 Output Description 1	Days Hours Min.	03/08/19	9. Birthplace (State or Foreign Country) MD
	uryland show	_	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 🕅 Yes 2 🗆 No	
	the Market Property P	recto	MD N/A BALTIMORE 10e. Street and Number 10f. Zi	p Code	10g. (Citizen of What Country?
	ath with	ral D	7231 PARK HEIGHTS AVENUE, APT. A	21208		USA
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any fujury or other traumatic event, the Medical Evaning must be notified at once.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ▼ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates: 13. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:	edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 2X) No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE
15-0	in 72 h	pletec	life DO NOT I	ork done during most of worki		Kind of Business/Industry
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land	should be fill and Mental H marked ott umarked ott umaric even	To Be	17. Father's Name (First, Middle, Last) JACK JOSEPH NURKIN	18. Mother's Name	(First, Middle, Maide	HEISMAN
Maryland	2 shour and M	-	1, 111	s (Street and Number or Rura		
	s 1 and f Health Item 27 other t		BERNICE SAMET / SISTER 7121 PAR 20a. Method of Disposition 20b. Place of Disposition (Na cemetery, crematory or	K HEIGHTS AVE		BALTIMORE, MD 21215 Location - City or Town, State
Baltimore,	Pages treent of I tant; If Ite		4 □ Donation 5 □ Other (Specify) HEBREW FRIE	NDSHIP 08/24	/2009 B	ALTIMORE, MD
Ball	permit Depar Impor any In			and Address of Facility SOI	L LEVINSON	N & BROS., INC. /ILLE, MD 21208
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the moshock, or heart failure. List only one cause on each line.			Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	+ Unknown Pa	nen	Onset and Death
	Examiner					
	uted d ansit	Examiner	Sequentially list conditions, and the conditions of the conditions			
60,	be exec cian an ourial-tra		resulting in death) Last Due to (or as a consequence of):			
68760,	rificate be executed og physician and as the burial-transit	Jedical	d			
P.O. Box	Physician: The law requires that the death cer this certificate has been signed by the attendin al director, page 2 should be detached for use.	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic 4 ☐ Pregnant at time of death 5 ☐ Other (s			23d. Date of delivery Month Day Year
	quires that en signed b uld be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying	cause given in Part I.		o use contribute to the cause of death?
Vital Records,	r: The law requir icate has been s ; page 2 should	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? No 1 □ Yes 2 □ No
Vit	ysiciar is certif director	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ ★0 Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ □	26. Place of Death	-	6 Dather (Specify) topahah
on of	ling Ph	ion: T	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work?	28d. Describe how in	
Division	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification: To	2 □ Accident investigation 3 □ Suicide 6 □ Could not be determined 28e. Place of Injury - At home, farm, street, facto building, etc. (Specify)	1 □Yes 2 □ No	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	the Hospital or hin 24 hours afte the Funeral Dir mpletely filled in	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurre 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.			
	To the within 2 To the comple	Me		9c. License number		Date signed (Month, Day, Year)
			30, Name and address of person who completed cause of death (Item 23a) (Type, Print)	D47683	8	123/29
				Ruskskown	40 M136	
	Sta Registr		Paymond Miller 25 Man Street Street 20. 31 Date filed (Month, Day, Year) AUG 26 2009 Klessen A. Space	hard		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 2 State of Maryland / Department of Health and Mental Hygiene 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 Month Physician Margaret K. Davis 10:15 PM 22 Aug. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Carroll Lutheran Village Carroll Westminster Birthplace (State or Foreign Country) 5. Social Security Number 219-12-7439 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 85 1 □ M 2 🗙 Maryland 10-19-1923 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inmoortant: I feem 27 Is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be marked. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Carroll Westminster 1 ☐ Yes 2√ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21158 USA 205 St. Mark Way Apt. 214 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Homemaker 17. Father's Name (First, Middle, Last)
Franklin Frederick Kirk 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Louise List 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William H. Davis-husband 205 St. Mark Way, Westminster, MD 21158 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Crem. 8-25-2009 Sykesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fletcher Funeral Home PA 254 E. Main St., Westminster, MD 21157 23a. Part1 Ento the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Card tomyopat hy Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burish-transit completely filled in by the funeral director, page 2 should be detached for use as the burish-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed' 2□No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA To 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: (Month, Day 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760,

State Registrar

Medical

29a Certifier

29b. Signature and title of certifie

and manner stated.

11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Westminsler, Hd. 2/158 32. Registrar's Signature

AUG 26 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 200 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HOSPITAL BALTIMO N/A QURS Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min. 1 X M 2 □ F MARYLAND 42 5-27-1967 Director 216-76-1394 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Medical Examinar must be notified at 1X Yes 2 □ No Director N/A BALTIMORE MD. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21229 USA 1214 N. AUGUSTA AVE. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 XNever Married 2 Married Maryland 21215-0036 Specify: BLACK 1 ☐Yes 2 X No Specify: <u>≽</u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) **PATHMARK** -12-RETAIL -0-18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GWENDOLA E. DAVIS JAMES JOHNSON ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau ODESSA DAVIS (MOTHER) 1214 N. AUGUSTA AVE. BALTIMORE, MARYLAND 21229 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State ARBUTUS MEMORIAL PARK 8-28-2009 BALTIMORE, MARYLAND 4 ☐ Donation /5 ☐ Other (Specify) D. HIBN R2. Name and Address of Facility PHILLIPS FUNERAL HOME. P.A. rvice Censer ONATHAK 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock/or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** CARDIOMV ERE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): P.O. Box 68760, signed by the attending physician be detached for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant for 1 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes 2 □ No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner Teath Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No • Hospital or Attendi 24 hours after death. • Funeral Director: A etely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Llace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 1 Deertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certiffer 00030355

5 V State

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

AUG 26 2009



Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 ENDY ELDRIDGE August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BURNIE ANNE BALTIMORE WASHINGTON MEDICENTER GLEN ARUNDEL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Year) Days 1 □ M 2 🕱 F 214-66-2734 DECEMBER 12,1957 MARYLAND Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2 XNo MARYLAND ANNE ARUNDEL BURNIE GLEN 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number HAROLD CT., 21061 U.S.A. 8140 APT, IA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: BLACK 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12TH GRADE CUSTOMER CORPORATE EXPRESS SERVICE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) CARL HOLMES MARTHA EDWARDS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8140 HAROLD CT., APT. IA, GLEN BURNIE, MD 2106 1 TERRY ELDRIDGE (HUSBAND) Place of Disposition (Name of gemeter), cremato for other place 20a. Method of Disposition 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee JR. FUNZRAL HOME 4240N. FULTON AVE, BALTIMORE, MD 21217 e disease, or complications that caused or tailure. List only one cause on each line 3a, Pari 1. Ent Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, e death. In mediate Cor se (Final disease or condition resulting in death) mort quence of); Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 XNo 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only on Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation

Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760, certificate director,

this

24 hours a

within 2

Physician

/Medical

Examiner

Funeral

Director

ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified #1

Department of Health and Mental Hygiene, Important: If Item 27 Is marked other than any injury or other traumatic event, the Magnee.

Physician

/Medical

filed within 72 hours after

Baltimore, Maryland 21215-0036

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Funeral Director

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Certification: To

examiner? 1∐Yes 2**∆**No 27. Manner of D ath

1 Natural 2 Accident 3 ☐ Sulcide

(Check only one)

29a. Certifier

6 ☐ Could not be determined 4 Homicide

29b. Signature and of certifier

and manner stated

1 ☐ Yes 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 🗌 No

D44973

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number

30.	Name and	address	of person	who	completed	cause o	of death	(Item 23a)	(Type,	Print)

State Registrar

AUG 26 2009

SAWHNEY, M.D., 301 Hospital Dr., Glen Burnie, MD 2016

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2009 ear Month Physician/ 22 Aug. 3:45pmM Edmonds Alfred Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number, 4c. County of Death **Examiner** Baltimore <u> Gilchrist Hospice @</u> Rehab Cente <u>Towson</u> Birthplace (State or Foreign Country) Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** Dec. 14 Hours 1 ₹ M 2 □ F T/953 239-92-9547 Yrs Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 1 XYes 2 No Baltimore N/A MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 21239 U.S.A. 5908 Yorkwood Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🖼 No Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: If Yes, Give Specify: Black Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Albatross Co. fitter 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Williams Edmonds **Emma** Johnny 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) |5908 Yorkwood Rd. Baltimore, Md 21239 Rochelle Rice-Edmonds/Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State GreenMountCrematoryAug.31,2009Balto.Md 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO. MD 2 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line set and Death Immediate Cause (Final Physician/ ea disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and the burial-trail Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 as nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) Pregnant at time of death 9 Unknown been signed by the a should be detached f Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performe 1 ☐ Yes 2 ☐ No certificate Yes 25. Was case referred to medical director. 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence Hospital 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ After this funeral 27. Manner of Dotth 28b. Time of 28a. Date of injury 28d. Describe how injury occurred 28c. Injury at Certificate: (Month, Day, Year) 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 24 hours after death. Accident Investigation filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical

State Registrar

29a. Certifier

29b. Signature

30. Name and

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only one

31. Date filed (Month, Day,

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and title of certific

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Year,

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Laddress of person who completed cause of death (Item 23a) (Type, Print)

Registrar's

within 24 hor To the Fune completed fi

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

P. marchy

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician 2009 8 3 estie /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1**™** M 2□ F 219-30-1728 Director VIRAINIA Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exercities must be rediffed at 1 Yes 2 □ No Directo MARYLAND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number JOODBROOK Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 | Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 No 2 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Health and Mental Hygiene. em 27 is marked other than College (1-4or 5+) FURNITURE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be V A M M MGEORGIANA ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s permit. Pages 1 and Department of Health Important: If item 27 any Injury or other troone. ELIZABETH FAUNTLERUY (WIFE) 2535 WOODBROOK AVE., BALTO., MD 21217 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State KING MEMORIAL PARK OE/28/2009 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
SOSEPH H. BROWN JR. FUNERAL HOME 21. Signature of Funeral Service Licensee 2140 N. FULTON AVE, BALTIMORE, MD 21217 hamo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** PesenTeric disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown s been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of death? certificate has page 2 autopsy performed 2 □ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) dire 1 Yes 2 Ho 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide the Hospital within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number :MD 147775326 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (HRISTOPHER M. FRAHLUN

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

barks

32 Registrar's Signature

22 5 Greene St

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Of Ma	ryland / Depa <i>Cel</i>	rtificate of E			g. No.2	09.	272	87
	Dhusisi	_	1. Decedents Name (First, Middle Last)				Date of Death Month	Day	Year	3. Time o	f Death
	Physici: /Medic	al	ILSAKI (FRANCIS				August		009		AM W
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or			4c. County			
and "			805 Buckingham Road	(In yrs. last birthday)	Cumber If Under 1 Year	Land If Under 24 Hrs.	8. Date of Birth		egany 9. Birth	nplace (State	or Foreign
	Funeral Director		152-24-3922 1□M 27☐F	80 Yrs.	Months Days	Hours Min	8. Date of Birth (Month, Day, Aug 20,	^{Year)} 1929	COL	many	
	/land		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation					10d. Inside C	•
	a-fsh	ctor	MD Allegany	Cumber1a	nd						No No
	vith the	Funeral Director	10e. Street and Number 805 Buckingham Road		10f. Zip Code	1502	10	og. Citizen of USA	What Coi	untry?	
	eath v	erai	11 Marital Status 12. Was Decedent E	ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No-	14. Ra		rican Indian,	
980	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "Adral Even incompation of the profiled at the content of the con		1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced Armed Forces? 1 ☐ Yes 2 ☑ M If Yes, Give Year or Dates:	lo	If Yes, specify Cuba 1 □ Yes 2 🔀 No	n, Mexican, Puerto Specify:	Hican, etc.)		Black, White, etc. Specify: white		
2-0	72 hou natura	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give	edent's Usual Occupa kind of work done of DO NOT use retired	ation Juring most of work		16b. Kind of E	Business/I	Industry	unk
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ld 2	il Hyg other /ent, I	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, N	laiden Surna	me)		
Maryland	Mental Mental arked c	2	Georg Rebenauer			Maria B					
lar)	2 should and Mer is marke aumatic		19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ing Address (Street a	and Number or Rui	al Route Number	. City or Towi	ı, State, Z	Zip Code)	
	1 and 2 Health em 27		Evelyn Walters/daughter	805	Buckingha	m Road Cı	mberland	1, MD 20c. Location	2150)2 Town, State	
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify)		osition (Name of ematory or other plac	e) !	pate	EGG. EGGENON	O., G.		
Balt	permit. Page Department of Important: If any Injury or once.		exerce //// fee	ector S Ba	22. Name and Address tate Anato altimore,	omy Board MD 2120	1		ore		
			23a. Part . Enter the disease, or complications that caused shock or heart failure. List only one cause on each line.	the death. Do not en	nter the mode of dyin	ng, such as cardiac	or respiratory arr	est,		Approxima Interval B Onset and	etween
No.	Physician /Medical		Immediate continuon disease or continuon a. Africasulting in death)	SDIO QUEU	101+4RY	HARE'S	1				
T	Examiner		Due to lor as	a consequence of):	DICTION	=R					
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequence of):	712 131 1	-/-)					
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O. Box (Physician: The law requires that the death certific this certificate has been signed by the attending praid director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown			3d. Date of delivery Month Day Year		Year			
σ.	ires that t signed by d be detac	by Ph	Part II. Other significant conditions contributing to death b	en in Part I.	23e. Did tobacco use contribute to			o the cause o Probably 4 □			
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o L	ding Ph h. After th funeral		27. Manper of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Inju (Month, Da		Wor	Ŕ?	28d. Describe h	ow injury occ	urred		
sio	ttendi death. tor: /	icati	2 Accident investigation 3 Suicide 6 Could not be 28e Place of In	ury - At home, farm, s		lYes 2 □No	28f. Location (S	treet and Nu	mber or F	Rural Route N	umber,
Division	after after I Direct	Certification:	4 Homicide determined building, el	c. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Tow	n, State)			
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier 1 Certifying Physician: To the best (Check only one) 2 Medical Examiner: On the basis and manner st	of examination and/or	ath occurred at the ti investigation, in my	ime, date and place opinion, death occu	e, and due to the urred at the time, o	cause(s) and date and plac	manner a e, and du	as stated. ie to the caus	e(s)
	To the within To the compl	Me	29b. Signature and title of confiler		29c. Licens	16041		8	-20	oth, Day, Year -09	
			30. Name and address of person who completed cause of	death (Item 23a) (Type	Print) MET	2.Cap. 5	un F301	Can	REX.	Y CIVILLY	M
	St	ate		rar's Signature	4 4	1	11/~ /			/	
	Regist	rar	AUG 2 6 2009 Pertura	1 19. Jaa	aked						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Month Physician 25, 2009 Rosella Funk August 5:45AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Brinton Woods Nursing Home Sykesville Carroll Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Days Hours Min. 1 □ M 2 ⋤ F Director 93 Jan. 31, 1916 PA 217-28-1350 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show / is marked other than "natural", or items 23a or 28a-f st traumatic event, the Wedical Examinar must be notified 1 ☐Yes 2 No Director MD Carroll Finksburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Departmit. Pages 1 and 2 should be filed within 72 hours after death vegenment of Health and Mental Hygiene. Important: If item 27 is marked other than "matural" any injury or other traumatic event than "matural" any injury or other traumatic event than "matural". Funeral 3940 Gamber Road 21048 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼ No 14. Race - American Indian Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates: δ Specify: White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seamstress L. Grief Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ Lydia A. Saylor J. William Crissinger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4765 Sykesville Road, Sykesville, MD 21784 Son John W. H. Funk 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/27/09 Finksburg, MD Providence Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 21136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) scheme **Physician** /Medical Due to (or as a consequence of) Examiner Allen au Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a a consequence of) Examine Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) signed by the a o 9 Unknown 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 ☐ Yes 2 → No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 3 No After this certific funeral director, Be 25. Was case referred to edical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 Natural 5 Pending after death.

Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hou.

The Funeral D 29a. Certifier Medical 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29c. License number 29d. Date signed (Month, Day, Year) 29b, Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month

01

1000

Sulte 102

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

URNER

Year)

Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Certification: To Be Completed by Physician/Medical Examin
	t	V	
	H	S Regis	tate strar
DH	MH 1	7 Rev 1	/2001

	-	For State		State of Ma	aryland		artment of H rtificate of I			lental Hy		an en in	0	22000
		Registrar 1. Decedent's Name (First, Mi	iddle I a	et)			imodio or i			2. Date of De	Reg. No	200	i had	3. Time of Death
ician dical		Robert Her								August	2 ² 4			7:45 Рм
niner	ı	4a. Facility Name (If not institu	ition, giv	e street and number)			4b. City, Town, or	Location	of Death			. County o		
		333 Broadw					Rockvi		0.11)			ontgo		<u> </u>
al or		5. Social Security Number 220–80–8428	6. 8	ı M n n n n n n n n n n n n n n n n n n	je <i>(In yrs. la</i> 49	a <i>st birthday)</i> Yrs.	If Under 1 Year Months Days	Hours	Min.	8. Date of Bi (Month, Di Nov. 8,	rth <i>ay, Year)</i> , 195		Cour	place (State or Foreign htry) land
	- 1-	Usual Residence of Decedent												
١.		10a. State 10b. Cou	nty		10c. City	, Town or Lo	cation						1	0d. Inside City Limits
once. To Be Completed by Funeral Director		Maryland Mont	gom	ery	Roc	kvill	e							YEYes 2□No
Director		10e. Street and Number					10f. Zip Code				10g. Ci	tizen of WI	hat Cour	ntry?
		333 Broadwo	hod	Drive				208	51		Unit	ed St	ate	S
Funeral		11. Marital Status		12. Was Decedent		3. 13.	Was Decedent of H	ispanic C	origin? (Sp	ecify Yes or N	0-			can Indian,
		1 Never Married 2 □ M	/larried	Armed Forces? 1 ☐ Yes 2 🔀			ir ves, specily Cuba 1 ⊡Yes 2 No			nican, etc.)			, White,	
2		3 ☐ Widowed 4 ☐ Divor	ced	If Yes, Give Year or Dates:			1 LIYes 2€4No	Specif	y:			Specify:	Whit	e
Completed		15. Dece	dent's E	ducation		16a. Dece	dent's Usual Occup	ation	et of work	ina	16b. K	Kind of Bus	iness/In	dustry
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		12				Head	of Secur					ocery		ain
Be (17. Father's Name (First, Midd								e (First, Middle)	
2		Robert Her	ıry	Fisher, Sr	· •			E	lsie	Mae Wh	itwo	rth		
'		19a. Informant's Name/Relati	onship	(Type. Print)		19b. Mailii	ng Address (Street	and Num	ber or Ru	ral Route Numi	ber, City	o <i>r Tow</i> n, S	State, Zip	Code)
		William L. Fi	Lshe	r / Brothe	er	333 B	roadwood	Driv	e, Ro	ockvill	e, M	ary1a	and_	20851
	Ī	20a. Method of Disposition			20b. Pl	lace of Dispo	osition (Name of matory or other place	e)		Date	20c. L	ocation - 0	City or To	own, State
		1 ⚠ Burial 2 ☐ Cremation 5 ☐ Othe					morial Parl	1		st 31,	Rock	ville	e. M	arvland
ja l	ł	4 Donation 5 Other (Specify) Parklawn Memorial Park 2009 Rockville, Maryland 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc.												
		Show	In	man	M01	1360 3	00 West Mor	mpare nteome	erv Av	enue.Roc	kvill	e, Mar	yland	i 20850–280
	+	23a. Part 1. Enter the disease	or con	nplications that cause	d the death									Approximate
	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Sudden Cardiac Death											Interval Between Onset and Death		
n I		disease or condition resulting in death)		м			Death							
r		,	- (Due to (or as										
<u>a</u>		Sequentially list conditions,		b. Cardi									_	
Examiner		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	≺	200 10 (01 40	a concequ	.01,00 01,1								
Xar		that initiated events resulting in death) Last	1	c Due to (or as	a consequ	ience of):								
 														
dical			-	d										
Į		IF FEMALE:		23c. If yes, outcome	e of pregna	ncy						23d. Date	e of deliv	erv
ie		23b. Was decedent pregnant in the past 12 months?		1 ☐ Live birth 4 ☐ Pregnant	2 🗌 Fetal	death 3[☐ Ectopic pregnand ☐ Other (specify) _	:y				Mor		Day Year
Physician/Me		1 □ Yes 2 □ No 9 □ Unknown	i	9 Unknown	at time of d	cuii 51								
		Part II. Other significant con	ditions	contributing to death t	out not resu	ulting in the u	inderlying cause giv	en in Par	t I.	23e. Did	tobacco	use contri	ibute to t	the cause of death?
2	2	Pulmonary I	-mho	lism		Ü	, ,			1 🗆	Yes 2	2 K No	3□ Pro	bably 4 🗌 Unknown
Completed		I dimonary_1		TISII								1		
										24a. Wa	opsv	p	rior to co	opsy findings available ompletion of cause of
j	5									1 □Yes	formed? 2 XIN		eath?	2 □No
B	۱ د	25. Was case referred to med examiner?	dical				Tau		ce of Dea	th (Check only	one)			
P		1∭ Yes 2 □ No		Hospital: 1 Inpati			nt 3 □ DOA Oth		Nursing H	ome 5 Res				ify)
2		27. Manner of Death 1 ☑ Natural 5 ☐ Pe	ndina	28a. Date of Inj (Month, Da	ury <i>ay, Y</i> ea <i>r)</i>	28b. Time of Injury	Wor	k?		28d. Describe	how inju	ary occurre	ed	
ite		2 ☐ Accident inv	estigation					Yes 2	□No					
1ifii			termine	28e. Place of in	jury - At ho tc. <i>(Specif</i>)		reet, factory, office			28f. Location City or To	(Street a own, Sta	and Numbe te)	er or Rur	ral Route Number,
Certification	3													
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Medical	3	one)		and manner s										
2	:	29b. Signature and title of cer		72.11	* * *		29c. Licens	se numbe	r					, Day, Year)
		1926br	(×4	- BAII	WD		D.5	3317	7		Αι	igust	25,	2009
		30. Name and address of per												
		Joseph A. Ball	1, M	.D. 16220	Fred	erick	Road #213	3, Ga	aithe	rsburg,	Mar	cylan	d 20	877
tate		31. Date filed (Month, Day, Y	ear)	32. Pégist	trar's Signa	ture	backel							
strar		AIIG	26	2009 Dens	un	p. 14								
	_	n U St												_

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 20b, PerFH 8894 8/26/09 TT State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Vear **Physician** 9.45PM FRIEDMAN INAH 200 +UCrusT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ENVOY OF PIKESVILLE BALTIMORE BALTIMORE Birthplace (State or Foreign Country)
 MD 8. Date of Birth (Month, Day, Year) 12/06/1922 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Days Min. 1 □ M 2 X F Months Hours 218-18-4522 86 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evantment per notified at 1 ☐ Yes 2 X No Director MD CARROLL HAMPSTEAD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 and 2 should be filed within 72 hours after death with Health and Mental Hygiene. 21074 4040 FARM WOODS LANE USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 □Yes 2X No Specify WHITE Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **BOOKKEEPER** SHOFER FURNITURE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be bepartment of Health and Merimportant; If item 27 Inaportant; It HARRY HERONDORF IDA GORDON ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALBERT FRIEDMAN/SON 4040 FARM WOODS LANE, HAMPSTEAD, MD 21074 20b. Place of Disposition (Name of Approved Company of other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Dogation 5 ☐ Other (Specify) 08/24/2009 BALTIMORE, MD Dogation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Funeral Service Dicente 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cache on each line. Approximate Interval Between Onset and Death Immediate Cause (Final FIHEROSCHEROTIC ARDIO VASCULAR DISEASE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of and burial-trar Due to (or as a consequence of): physician Completed by Physician/Medical the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for Month Year Day 5 ☐ Other (specify) signed by the a I be detached fo 1 ☐Yes 2 Z No 9 Unknown 9 Unknown Partil. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? EMENTA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown FAILURE HRIVE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed?)STED POROSIG certificate 2 No 1 □Yes 1 ☐ Yes 2 2 No Be 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 No 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

The law requires that the death certificate be executed P.O. Box 68760, of Vital Records, Hospital or Attending Physician: Division after death. filled in by 24 hours a Medical completely within 2 To the I

Baltimore, Maryland 21215-0036

State Registrar

26

ASNEEM

29a. Certifier

(Check only

29b. Signature and title of certifier

MI 32 Registrar's Signature 31. Date filed (Month, Day, Year)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

2835

Leftifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

AVE, SUITE 203

29d. Date signed (Month, Day, Year)

MI)

2120

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AUGUST 21 2009^{ear} 4:42 A **JEFFRFY FOREMAN** Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death GILCHRIST HOSPICE CARE TOWSON BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, Funeral Birthpo Country) MD Min. 1 □**X**M 2 □ F Hours 10-07-1947 61 Director 218-44-5978 Usual Residence of Decedent marked other than "natural", or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD BALTIMORE HUNT VALLEY 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA ONE SHEEPFOLD LANE 21030 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 If Yes, Give 1 Never Married 2 X Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗶 No Specify: Specify: WHITE 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) CONSULTANT **COMPUTERS** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LEONARD SOL **FOREMAN** JEAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NANCY FOREMAN/WIFE SHEEPFOLD LANE, HUNT VALLEY. MD 21030 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 08-24-2009 REISTERSTOWN, MD 4 Donation 5 Other (Specify) BALTIMORE HEBREW SOL LEVINSON & BROTHERS, INC. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Complications Priysician/ brain (anw disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Pregnant at time of death 2 🗌 No 9 Unknown 9 Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Type II cate has been sig , page 2 should b 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? After this certificate I 1 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Gilchist within 24 hours area.

To the Funeral Director: After this of the funeral directors are funeral directors. 욘 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) R149194 August 21,2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Char Marian Grant 6701 31. Date filed (Month, Day, Year) AUG 26 State Registrar

			- FOF	partment of Health and Certificate of Death		ne No.2009 27292	
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) SYLVAN	FRIEMAN	2. Date of Death AUGUST	^{Day} 22 2009 5:46 A M	
No.	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea		4c. County of Death	
- t			2304 VELVET RIDGE DRIVE 5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	OWINGS MILL av) If Under 1 Year If Under 24 Hrs		th 9. Birthplace (State or Foreign	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho 217-20-3451 1 M M 2 □ F 81 7. Age (In yrs. last birtho	Months Days Hours Min		28 Country) MD	
	and w		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town o	r Location		10d. Inside City Limits	
	Maryla -f sho	tor		WINGS MILLS		1 □ Yes 2) No	
	or 28a	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?	
	ath wir		2304 VELVET RIDGE DRIVE	21117		USA	
980	be filed within 72 hours after death with the Maryland ttal Hygiene. ad other than "natural", or Items 23a or 28a-f show event, its in deal Evai, its rivilled at	by Funeral	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 X No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE	
5	72 ho 'natur	eted	(Specify only highest grade completed)	ecedent's Usual Occupation live kind of work done during most of wo	orking 16b	b. Kind of Business/Industry	
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<u>و</u>	e filed al Hyg other vent, I	Be C	17. Father's Name (First, Middle, Last)		me (First, Middle, Maid		
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altimore, Maryland 21215-0036	d 2 should Ith and Mer 27 is marke traumatic		1,171	lailing Address (<i>Street and Number or F</i> BO4 VELVET RIDGE DI			
Ē,	is 1 and of Health item 27 other t		20a. Method of Disposition 20b. Place of D	sposition (Name of crematory or other place)		c. Location - City or Town, State	
E	Pages ment of ant: If ite ury or o		1 LA Burial 2 Li Cremation 3 Li Removal from State 1	NAI CEMETERY 08/2	24/2009	DWINGS MILLS, MD	
Balt	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en once.	(21. Signature of Funeral Service Liotings	22. Name and Address of Facility 8900 REISTERSTOWN	SOL LEVINSORD., PIKES	ON & BROS., INC. SVILLE, MD 21208	
ı			23a. Fart1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	24		Onset and Death	
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	Examiner		CALDIAN !				
	sit ed	iner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	be executed sician and burial-transit	Examiner	cause (bisease or injury that initiated events resulting in death) Last c			-	
8760,	cate be only sicial the buri	dical E	d	,			
9	ertifica ling ph e as th	Med	IF FEMALE:				
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year	
ds, P.	uires that n signed b Id be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death? 2 No 3 Probably 4 Unknown	
Records,	aw requir is been s 2 should	Completed			24a. Was an	24b. Were autopsy findings available	
	The law cate has page 2 s	Som			autopsy performed 1 □ Yes 2		
Vita	slcian; Th certificate rector, pag	Be	25. Was case referred to medical examiner?		eath (Check only one)		
ot	Phys	- T	1		Home 5 Residenc	e 6 Other (Specify)	
o D	nding F ath. r: After e funera	atior	1 Natural 5 □ Pending (Month, Ďay, Year) Inju 2 □ Accident investigation				
Division of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification prietable filled in by the funeral director, completely filled in by the funeral director,	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)	
	To the Hospital within 24 hours a To the Funeral completely filled	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, one the desired physician in the desi				
	To the within 2	ž	29b. Signature and title of certifier	29c. License number		. Date signed (Month, Day, Year)	
)		1	20 Name and address to perform the completed was at death (the control of	D-2048L Pe, Print) 2136 - 21276		212/09 11:00 An,	
	y)		30. Name and address of person who completed cause of death (Item 23a) (Ty	2130 - 2ALTE	· MO .	21206	
	Sta		31. Date filed (Month, Day, Year)	harded			
	Registr	ar	AUG 2 6 2009 Jenus S.	Con Contraction of the Contracti			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** Phyllis Gray **AUGUST** 11:51P M Mary 20 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Saint Joseph Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2√2 F 213-34-8246 Feb. 28, 1937 Maryland Director Usual Residence of Decedent 10a. State 10d. Inside City Limits 10c. City, Town or Location show traumatic event, the Midical Examiner must be notified at 1 ☐ Yes 2 X No Director Perry Hall MD Baltimore 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a or 21236 USA 202 9530 Perry Hall Blvd. Apt. Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or items, 11. Marital Status 1 ∐Yes 2√ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 XNo Specify þ 3 ₩ Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) At Home Homemaker marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) in and 2 should be fill Health and Mental Hem 27 is marked oth Be Ethel Adele Lowman James Henry Moll 2 19a. Informant's Name/Relationship (Type. Print) 8522 Kings Ridge Road-Parkville, Maryland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once. James Gray-son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Moreland Memorial Aug. 24, 2009
Parkville, Maryland 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 8800 Harford Road Parkville, MD 21234 Evans Funeral Chapel and Cremation Services Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician ACUTE PULMONARY EDEMA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ACUTE MYOCARDIAL INFARCTION if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) burial-Box 68760, physician Physician/Medical the 38 attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 pronths?

1 Yes 2 No 3 🗆 Ectopic pregnancy Month Year 5 Other (specify) Ö been signed by the should be detached 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ LUNG 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy perform certificate 1 ☐ Yes director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To After th funeral 27. Manner of Death 1 1. Natural 2 Accident 28a Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending investigation death. 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fu 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my opinion, death according to the cause of the 29a. Certifier Medical

State Registrar DHMH 17 Rev 1/2001

(Check only one)

KHOSROW

29b. Signature and title of cer

31. Date filed (Month, Day, Year)

AUG 26 2009

asker

7601

32. Registrar's Signature

and manner stated.

M. D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TARASSI

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number D46356

OSLER DRIVE

29d. Date signed (Month, Day, Year)

TOWSON, MARYLAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 10:50 P M Raymond Morrison Geisendaffer, Sr. August 21, 2009 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore Parkville 8 700 Wende II. Avenue If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1 2/24/1922 Birthplace (State or Foreign Country)
_ 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours Min 1 XM 2 □ F 86 217-14-2707 Maryland Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. Count Parkville Baltimore 1 ☐ Yes 2X No MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21234 US.A. 8700 Wende II Avenue Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X Yes 2 □ No If Yes. Give 1 Never Married 2X Married 1 ☐ Yes 2 🕱 No White Specify 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Amtrak Conductor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert Geisendaffer Mary Berger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 8700 Wendell Avenue, Parkville, MD 21234 Audrey Geisendaffer/Wife 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other of the constant Chapel 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 08/27/09 Forest Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) Bel Air 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services 21. Signature of Funeral Service Licenses 8800 Harford Rd. Parkville, MD 21234 Approximate Interval Between Onset and Death 2/a. P. rt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s lock, or heart failure. List only one cause on each line. immeriate Cause (Final disease or condition restring in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 No Was case referred to medical examiner? 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Examiner law requires that the death certificate be executed o Records, of Vital Hospital or Attending Physician:

physician a s the burialnding p nse atten for us ed by the a signed by the detach page certificate After n 24 hours after death.

The Funeral Director: A pletely filled in by the fu the within 7

Physician

Examiner

Funeral

Director

show

Director

Funeral

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Completed

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Examine

Physician/Medical

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Certification: To

Medical

29a. Certifier

ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

is marked other than

If item 27

Department of 5

Physician

/Medical

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pe and Mental

Pages 1 and 2 should

Maryland

/Medical

State Registrar

and address of person who completed cause

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

death (Item 23a) (Type, Print)

Date filed (Month, Day,

Year) 6

32. Registra

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** (Farin August 2002 Joseph 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner of University Maryland Medical Baltimore Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/08/1940 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days 1 M 2 □ F 69 Maryland 212-36-0864 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10h County 10a State or 28a-f show 1 ☐ Yes 2 No Director Pasadena Anne Arundel MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21122 is marked other than "natural", or items 23a 213 Oak Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Q 5 9 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status orces? 2 No 1958 -1 Yes 2 ☐
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify Specify: White 1962 þ 3 ₩idowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 US Government-Navy College (1-4or 5+) Electrician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Agnes G. Burkhardt ပ Arthur F. Gavin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau
once. <u> 200 Sillery Road, Pasadena, MD 21122</u> Dennis Gavin / Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ■ Burial 2 Cremation 3 Removal from State 08/24/09 Crownsville, MD MD Veterans Cem 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility G.J. Gonce Funeral Home, PA 21. Signature of Funeral Service Licensee 169 Riviera Drive, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Uremia disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** cute Tubular Sequentially list conditions Examiner tany, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Attending Physician: The law requires that the death certificate be executed Hypotension
Due to for as a consequence of): attending physician patocellular Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐ Yes 2 ☑1√0 1 inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No spital or Attendii nours after death. neral Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital or within 24 hours at To the Funeral D 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Ismai

AUG

Dina

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Greene

MO

South

32. Relistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22

29c. License number

722955

29d. Date signed (Month, Day, Year)

Street Baltimore Maryland 21201

		,	1 - For State Registrar	State	of Marylar	-	rtificate of			F. 13 G	27295
			Decedent's Name (First, Middle	, Last)					2. Date of Dea	ith	3. Time of Death
	Physicia		Charles	L.	Gottleik	o Sr.			Month	Day Ye 22 200	
	/Medic		4a. Facility Name (If not institution				4b. City. Town, o	r Location of Death		4c. County of D	eath
	Examini	E	962 Duvall Hig	-	,		**	asadena		Anne A	rundel
	uneral			6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birtl	h 9.	Birthplace (State or Foreign Country)
	irector		216-03-4709	1 ☑M 2 ☐ F		90 Yrs.	Months Days	Hours Min.	Jan. 2	y, rear) 3 1919	MD MD
			Usual Residence of Decedent								
ylanı	Mort III		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
Mar	P-f s	į	Maryland Anne	Arundel			Pa	sadena			1 □Yes 2 및 No
h the	r 28	ire	10e. Street and Number				10f. Zip Code			10g. Citizen of What	Country?
h wit	23a c	a D	962 Duvall Hig	hway				21122		Ţ	ISA
deat	Ems	Funeral Director	11. Marital Status	12. Was De	cedent Ever in U	.S. 13. \	Was Decedent of H	lispanic Origin? (S	pecify Yes or No-	14. Race - A	merican Indian,
after	or ite	교	1 ☐ Never Married 2 ☐ Marri	Armed F	2 🗔 No		l ⊡Yes 2 ⊡rNo	an, Mexican, Puert Specify:	o nicari, etc.)	Black, W	Mhite
3 an	ENG.	l by	3 ☐ Widowed 4 ☐ Divorced	If Yes, O Year or	Dates:		THES ZIMINO	Зреспу.		Specify:	WIIICE
2 hc	natu fical	Completed	15. Decedent' (Specify only highes	s Education	0		ient's Usual Occup	oation during most of wor	kina	16b. Kind of Busine	ss/Industry
tii r	an 1	ng.	Elementary/Secondary (0-12)	1	(1-4or 5+)	life. L	OO NOT use retired	d)	N.I.I.G		
N P	er th	Ö	6				Parts Ma	anager		Dies	els
2 ∰ €	yent vent	Be (17. Father's Name (First, Middle, L	.ast)				18. Mother's Nan	ne (First, Middle,	Maiden Surname)	
ald b	arkec atic e	၉	John Got	tleib	<u> </u>			Mary	Α.	Oppel	
Sho	is mis		19a. Informant's Name/Relationsh	ip (Type. Print)		19b. Mailin	g Address (Street	and Number or Ru	ıral Route Numbe	er, City or Town, Stat	e, Zip Code)
and 2	and 127		Charles L. Gottl	leib Jr.	(son)	2626	0 McCart	hy Lane,	Greensb	oro, MD 2	1639
S 2	ite i		20a. Method of Disposition		20b. J	Place of Dispor	sition (Name of natory or other plac	ce) 7.1367	Date 26	20c. Location - City	or Town, State
Page	i ii i		1 ⊠Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		n State I		en Cemete	irug.	009	Glen Burn	ie, Maryland
i i	Department or neath and wenter Trygene. Importants if then ZT is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Eva.; incr., ust be notified at once.		21. Signature of Funeral Service (^	22	. Name and Addre	T104.		s Funeral	Home, P.A.
ž 2.	impo any li		bh.	Jan 1	/) _v		3111 Mon			dena, MD	
	- 6		23a. Part 1. Enter the disease, or o	complications that	ca sed the deat	th. Do not ente					Approximate Interval Between
Phy	sician		shock, or heart failure. List o Immediate Cause (Final	only one cause on	each line.		14.				Onset and Death
3	ledical		disease or condition resulting in death)	a. Due to	o (or as a consec	mence of):	11/01				-
Exa	aminer			540	7 (01 40 4 0011004	J.	Jones	tra			
		ē	Sequentially list conditions, if any leading to immediate	b Due to	o (or as a conseq	juence of):	7-11-0	114			
uted	ansit	min	cause. (Disease or injury that initiated events resulting in death) Last								
exec	ial-tra	Examiner	resulting in death) Last	Due to	o (or as a conseq	juence of):					
icate be executed	our	edical		d							
	윤두										
The law requires that the death certif	attending for use as	sician/M	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna					23d. Date of	delivery
Jeath	atte	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No		e birth 2 Feta gnant at time of		Ectopic pregnanc Other (specify) _	У		Month	Day Year
j j	by the	Ş	9 Unknown	9 □ Uni	known						
that	9 8	y Phys	Part II. Other significant condition	ns contributing to	death but not res	ulting in the ur	derlying cause giv	en in Part I.	23e. Did to	bacco use contribut	e to the cause of death?
in Series	sign Id be	d by							1 □ Y	es 2. No 3. □	Probably 4 Unknown
	s peen s	Completed							04= Wee	O4b 14/av	autonou findingo quallabla
je lav	has je 2	ш							24a. Was a autop perfor	sy prior	autopsy findings available to completion of cause of
<u>`</u> ≓	certificate ha									2 💆 No 1 🗆 `	
Physician:	After this certific funeral director,	a	25. Was case referred to medical examiner?	Hospital:			Oth	or:	th (Check only or		
S E	this aldii	e.	1 Yes 2 No	1 1		ER/Outpatien	t 3 DOA	4 LI Nursing H		lence 6 Other (S	Specify)
- 6	After	<u>8</u>	27. Manner of Death 1 Natural 5 Pending	(Mo	e of Injury onth, Day, Year)	28b. Time of Injury	Wor		28a. Describe n	ow injury occurred	
Attending	tor:	cat	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	nt he				Yes 2 ☐ No			
or A	irec in by	Certification:	4 ☐ Homicide determin	and 28e. Plac	ce of Injury - At hidding, etc. (Special	ome, tarm, stre <i>fy)</i>	eet, factory, office		City or Tow	itreet and Number o. ⁄n, State)	Rural Route Number,
oital	iled iled		00- 0-455 456								
S	un ≥	Medical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	xaminer: On the	basis of examina	owieage, death ation and/or inv	r occurred at the ti restigation, in my o	me, gate and place opinion, death occu	e, and due to the curred at the time, o	cause(s) and manne date and place, and	r as stated. due to the cause(s)
¥ 4	4 5		UTIC)	and ma	riner stated.						
thin 24	the F	Med	29b. Signature and title of certifier		_		29c Licens	e number		29d. Date signed /M	
To the Ho	To the Funeral Director: Af completely filled in by the fur	Med	29b. Signature and title of certifier		17		29c. Licens	e number	7	29d. Date signed (M	
To the Ho	To the F	Mec	* //		1		0	3155	7	August	
To the Ho	To the F	Mec	29b. Signature and title of certifier 30. Name and address of person w	no completed car	use of death (Iter	m 23a) (Type, I	0	3/J/	1	August	
To the Hc	1		* //	no completed car	use of death (Iter	m 23a) (Type, I	0	31 FT	10siv	August August August	

Examiner **Funeral** Director Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Evans and injury or other traumatic event, the Madical Evans and injury or other traumatic event, **Physician** /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Director

Completed by Funeral

Be

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Examine

Be Completed by Physician/Medical

Medical Certification: To

For State	State of Ma		artment of Health and	wemai nygie	5116	
Registrar		Ce	rtificate of Death		. No. 2 0 0 0	27297
I. Decedent's Name (First, Middle, Las	•			2. Date of Death Month	Day Year	3. Time of Death
Gloria Irene a. Facility Name (If not institution, give		aman	4h Oit Town or Location of Doct	August	23, 2009	11:15 P ^M
		1 6	4b. City, Town, or Location of Deat	n	4c. County of Dea	
Greater Baltimo Social Security Number 6. Se		L Center e (In yrs. last birthday)			Baltimor	thplace (State or Foreign
186-28-3830	☐ M 2 🔀 F	75 Yrs.	Months Days Hours Min.	Jan. 03	(ear) Co	ouintry) PA
sual Residence of Decedent						
Da. State 10b. County		10c. City, Town or Lo	ocation			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
Maryland Anne Ai	rundel		Linthicum		011	
0e. Street and Number			10f. Zip Code	109	. Citizen of What Co	
309 Viewing Avenu	12. Was Decedent E	iver in IIS 12	Was Decedant of Historia Origin (S	posity Vos or No	USA 14. Race - Ame	
1. Marital Status 1 □ Never Married 2 □ Married	Armed Forces? 1 ☐ Yes 2 ☐ N	0	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	Black, Whit	
3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No Specify:		Specify:	White
15. Decedent's Edu	ucation	16a. Dece	edent's Usual Occupation	16	b. Kind of Business	/Industry
(Specify only highest grad	College (1-4or 5+	`life.	e kind of work done during most of wor DO NOT use retired)	king		
12			Homemaker		House	ehold
7. Father's Name (First, Middle, Last)	II - <i>E E</i>			ne (First, Middle, Mai	,	
Harry Harrison			Zelda		ıntzer	
9a. Informant's Name/Relationship (T	ype. Print)		ng Address (Street and Number or Ru			Zip Code)
Patricia Barlow Da. Method of Disposition	(daughter		Viewing Avenue, I	inthicum,	MD 21090	
				Doto	a Lagation City as	Taum Chat-
1 ☐ Burial 2 ☐ Cremation 3 ☐ Partial 2 ☐ Cremation 3 ☐ Partial 2 ☐ Other (Specify,	Removal from State	cemetery, crei	osition (Name of matory or other place) ematory Inc. 2	. 25	c.Location-City or	•
4 ☐ Donation 5 ☐ Other (Specify,)	Metro Cr	ematory or other place) ematory Inc. Aug 2 Name and Address of Facility	. 25 009 Ba Stallings	ltimore,	Maryland Home, P.A.
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attending physician and for use as the burial-transit sate has been signed by the page 2 should be detached within 24 hours after death.

To the Funeral Director; After this certificate has been and prefetely filled in by the funeral director, page 2 should

25. Was case examiner? 1 ☐ Yes 27. Manner of 1 Natura 2 Accide 3 Suicid 4 🗆 Homic 29a. Certifier and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier Cuntuia Smallo Mo

D0051347

8/24/09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
CYUTHIG SOCIAND MO 6701 NCHAILES ST BALTIMORE MD 21204

State Registrar

		1 = For State Registrar		•	epartment of F Certificate of I	Death		leg. No.	000	2720
Physici		1. Decedent's Name (First, Middle, MARK DOUE	,	ENDER	SON		2. Date of Dea Month August	th Day 20	Year 2009	3. Time of Death 10:54 A.
/Medid Examin		4a. Facility Name (If not institution,				Location of Death	, , , , , , , ,	4c. Co	unty of Death	
		2616 West Wood			Dunda hday) If Under 1 Year	llk If Under 24 Hrs.	0 D-1(D-1)		Baltimo	
Funeral Director		unk.	5. Sex 7. A	Age (In yrs. last birt 41	Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day March 1	, Year)		place (State or Fore ntry) On Maryla
MC T		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				1	0d. Inside City Lim
-f sho	ģ	Maryland Balt	imore	Du	undalk					1 ☐ Yes 2 🔀
r 28a	Directo	10e. Street and Number			10f. Zip Code			10g. Citizer	of What Cour ced Sta	ntry?
23a c		2616 West	Woodwell R	load	2	21222			Americ	
Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show my hiury or other traumatic event, the Medical Evaruner must be notified at once.	by Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Marrie	If Yes, Give	⊒ ਔο ≥3	13. Was Decedent of H If Yes, specify Cuba 1 □ Yes 2□No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		Race - Americ Black, White, pecify:	
atural"		3 ☐ Widowed 4 ☐ Divorced 15. Decedent's	Year or Dates		Decedent's Usual Occup	ation		16b. Kind	of Business/In	
e. Medik	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4o		(Give kind of work done of life. DO NOT use retired	during most of work	ing	Fast	Food	-
Hygien other than	Son	12			sales cle				aurant	
d oth d oth event	Be	17. Father's Name (First, Middle, Li	•	020000		18. Mother's Name		Maiden Su	rname)	
and Mental Hygir is marked other aumatic event, It	은		uglas Hend			Joan Ar		Oit T	Chata 7	- Code)
th and 7 is n traun		19a. Informant's Name/Relationshi		F	Mailing Address (Street 516 West Woo					
nent of Health ant: If item 27 i ury or other tra		20a. Method of Disposition 1 ☐ Burial ②□ Dremation	3 ☐ Removal from Stat	20h Place of	Disposition (Name of y, crematory or other place 5 Funeral el- Bel Air		oate St 25,	20c. Loca	tion - City or To	own, State
Departme Important any injury once.		4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service L		/ Chape	22 Name and Addre	ss of Facility				Marylan
any p	10 h	23a. Part 1. Enter the disease, or c shock, or heart failure. List o	514	7		ork Road	Timoni	un, k	remati Jarylan	on Ctr., d 21093 Approximate
Medical aminer sthe prize priz	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. ARHY Due to (or a) b. CARD Due to [or a)	as a consequence of	of): >ATHY of):					Onset and Deat
oy the attending ached for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant condition	4 ☐ Pregnan 9 ☐ Unknow	n 2 🗀 Fetal death t at time of death n	5 ☐ Other (specify) _		230 Did to		d. Date of deliv	rery Day Year
signe d be d	þ	Part II. Other significant condition	is contributing to deatr	i but not resulting in	i the underlying cause giv	en in Part i.				bably 4 7 Unkn
iis certificate has been signed f director, page 2 should be det	Completed						24a. Was autop perfor 1 □Yes	sy		opsy findings avai ompletion of cause 2 \(\sum \) No
certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:	** *****	Cth	26. Place of Deat				
f. After this of funeral dir	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigs	28a. Date of I		ime of 28c. Injury Wor	4 LI Nursing H	ome 5 Residence 5		, , , , , ,	ify)
₽ ₽	Certification:	2 Accident Investigs 3 Suicide 6 Could n 4 Homicide determin	ot be 28e. Place of	l Injury - At home, fal etc. <i>(Specify)</i>	rm, street, factory, office				Number or Rui	al Route Number,
ctor:	ē	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
n z4 nours after deatn. he Funeral Director: Af pletely filled in by the fur			xaminer: On the basi and manner							
within 24 hours after death. To the Funeral Director: Af completely filled in by the fur	Medical Cer	(Check only 2 Medical E			29c, Licens	se number		29d. Date	signed (Month	
within 24 hours after death. To the Funeral Director: After completely filled in by the fun		(Check only 2 Medical E				se number			signed (Month	, Day, Year)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 1:45 AM M 2009 13, Rose Holland August 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Joseph Richey Hospice Baltimore 8. Date of Birth (Month, Day, Ye)
June 17, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs, last birthday Days Year Country) Virginia Months Hours 1 □ M 2 😾 F 73 217-34-8812 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 □Yes 2√□No MD Baltimore Randallstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21133 USA 5401 Old Court Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify Specify: black. 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 0 caregiver heathcare 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert West Christine Boyd 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21133 Jackie Jones/daughter 3528 Carriage Hill Circle #202 Randallstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 🔁 Other (Specify) in 21. Signature of Funeral Service Licensee Ronald S. Wade, Director 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

23a. Par 1. Enter the the assect room to a ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart fullure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final MONAYS disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 3 🗆 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed?

Physician /Medical Examiner

permit. Pages 1 and 2 s Department of Health a Important: If item 27 Is any injury or other trau once.

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

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ner

Exami

Physician/Medical

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Completed

Be

Certification: To

Medical

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, it is I Medical Expressionar in the scaling of

Baltimore, Maryland 21215-0036

7

Aug 13,200

attending physician and for use as the burial-transit been signed by the atter cate has I page 2 s

requires that the death certificate be

ο.

Records,

Division of Vital

Hospital or Attending

this within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	
DIABETES MELLITUS	

					1000 20110
25. Was case referred to medical				th (Check only one)	-1
examiner? 1 ☐ Yes 2. No	Hospital: 1 ☐ Inpatient 2 ☐	BR/Outpatient 3 □ □	OOA Other: 4 Nursing H	lome 5 ☐ Residence €	G □ Other (Specify)
27. Manner of Death 1 Adatural 5 Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury	/ occurred

	1 Accident	5 ☐ Pending investigation	(Monar, Day, rear)	M	1 □ Yes	2 🗆 No	
	3 ☐ Sulcide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of Invery - At he building, s.c. (Specif	ome, farm, street, facto ý)	ry, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)
П		1					

29a. Certifier	Certifying Physician: lot	herbest of my knowledge, death occ	urred at the time, date and place, and due to the gation, in my opinion, death occurred at the tim	ne cause(s) and manner as stated.
one)		ner stated.	gation, it my opinion, death occurred at the tim	e, date and place, and due to the outset(s)
			20 11	COL Data signed (1 forth Day Voor)

29b. Signature and title of certifier

Likeled At Stolerk 08/14/2009

30. Name and address of person	who completed cause of death (Item 23a) (Type, Print)	1-7	
SMADOFT 1	who completed cause of death (Item 23a) (Type, Print) 10	2618 BACTIMORE	MA 21201
31. Date filed (Month, Day, Year)	32. Registrar's Signature		110

State Registrar

back

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #12,15 16a&istate of Maryand Perenament of and Wenter Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 2000 BENJAMIN HOOVER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SILVER Holy Cross Hospital SPRING MONTGOMERY If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday **Funeral** Months Days 10M 20 F 2 West Virginia 80 28 Director 1502 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at 1 Wes 2 □ No Director VER SPRIN MONTGOMERY 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò 90, USA items 23a UNK MIDDLEGAT Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 | Yes 2 | No 157-64 1 ☐ Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 ,o If Yes, Give Year or Dates: ģ 3 ☐ Widowed 4 ☐ Divorced WHITE "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) ₩₩ Government Cryptologist NEWS 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) Be Samuel Randolph Hoover Katherine Lacv 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15220 Middlegate Road Silver Spring MD 20905 19a. Informant's Name/Relationship (Type. Print)
Susan Hoover/spouse Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 N Donation 5 Other (Spacify) Signature of Euneral Service Lice 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** RESPIRATORY FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SEPSIS Sequentially list conditions, Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed SEPTIC SHOCK physician and s the burial-trans Due to (or as a consequence of) P.O. Box 68760, Physician/Medical BLADDER attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) the TYPS 2 No 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown PHEUMONI 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has by page 2 s autopsy performed? Yes 2 No this certificate 1 ☐Yes 2 ☑No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 6815 person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of RAJ NE X MD 1500 POREST GLEN RSI 31. Date filed (Month, Day, Year) 2. Registrar's Signature State

Registrar

AUG 26 2009

2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Ye ar **Physician** М 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 11163 Woodelves diumbia Wa Howard If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Gountry) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) Months Days M 2□ F Yrs. February 5, Director Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show if than "natural", or items 23a or 28a-f show Yes 2□No Director olumbia 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number USF Funeral X 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 22 100 If Yes, Give Year or Dates: **Army** 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 2 Married within 72 hours after 1 Never Married Baltimore, Maryland 21215-0036 2 1 No 1 ☐ Yes Specify: Black Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be Tarri City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, 19a. Informant's Name/Relationship (Type. Print) 21044 MD olumbia 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Kathmou 4 □ Donation 5 □ Other (Specify)

21. Signature of Funeral Service Licensee 22. Name and Addres 207 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Amyloid Cardiomyopathy /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions ner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of The law requires that the death certificate be executed Exami and burial-t Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the as IF FEMALE asn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy for Month Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Ö detached 9 Unknown s been signed by t should be detach 9 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy 1 ☐ Yes 2 ☐ No 1 □Yes 2 1 No of Vital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 ☐ Other (Specify) 1 🗌 Yes 3 NO 2 ER/Outpatient 3 DOA Medical Certification: To 1 Inpatient this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Puneral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital 29a. Certifier Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. the within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Man MD 21136 Chistosla Strut 17029 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 26 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#10e, perFH, G894, 8/26/09, WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month 09 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONITGOME VEIRS MILL KG RECKEVILL 103 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 6. Sex **Funeral** Months 1 □ M 2 K F Days Hours Min. 549-51-0955 SOUTH KORFA **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be mailined at MD MONHGOMETE Funeral Director ROCKVILLE 1 X Yes 2 ☐ No 10e. Street and NumbeVeirs Mill Rd. 10g. Citizen of What Country? 2085 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married 1 ☐Yes PNo If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Be Completed by Specify. 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be f ment of Health and Mental I ant: If Item 27 is marked of KWON, HOON ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or or Burial 2 ☐ Cremation 3 Removal from State NORDECK CEM -22-09 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundral Service Licensee 22. Name and Address of Facility 2019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** endome tria Cance 10 years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-transit has been signed by the attending physician and e 2 should be detached for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? After this certificate filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deatl Funeral Director; 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Center Dine #300

Rochille

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

,ND

50705

31. Date filed (Month, Day, Year)

AUG 26

9707 medical

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 26 pe verb., g894,08/26/09dbb
Reg. No.
Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** HARRIS RUDY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Randallstown Northwest Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 15, 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Funeral Min. Year, Days Hours 1 □ M 2 🖾 F July Arizona 65 Director 542-44-6820 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventment. 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2X No Directo Gwynn Oak Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21207 5509 Gwynn Oak Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 X No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: þ 3 ☐ Widowed 4 🖾 Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) office help 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) unk Be Marie Groth 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4310 Shoreline Drive North; Keizer, Oregon 97303 Renee Prettyman/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) In State 21. Signatur of Ronal In Service Licensee State Anatomy Board; 655 W. Baltimore Street Baltimore, Maryland 21201 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on _ach line. Approximate Interval Between Onset and Death Immediate Cause Einal disease or condition resulting in death) **Physician** eno carc inom9 /Medical Due to (or as a consequence of): Pr. Mary Unknown Examiner Dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) □Yes 2□No 9 ☐ Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ûnknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No After this certificate 1 ☐Yes 2 ☐No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice Hospital: 1 ☐ Yes No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 atural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: filled in by the 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 19 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RIB

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Year)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 15 Day Month Physician 2009 Christian R. Hansen 4:25 P M August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Auxiliary House Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Sex 1 ☑ M 2 ☐ F **Funeral** 579-10-0525 July 11, 1915 Director 94 Washington Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐Yes 2X No Directo Maryland Montgomery Bethesda 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5501 Southwick Street 20814 United States Pages 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene.

Int: If item 27 is marked other than "natural", or items 23 Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify Specify: White þ 3 X Widowed 4 ☐ Divorced Year or Dates:1933–1935 Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Attorney 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be မ Eija M. Rogild Hans F. Hansen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ann H. Lewis / Daughter 2022 Gov. Thomas Bladen Way #302, Annapolis, Maryland 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages 1 Department of the Important: If ite any injury or ol once. August 23, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. 2006 Bethesda, Maryland 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, Inc. 21. Signature of Funeral Service Licensee _ M01360 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Myocardial Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Hospital or Attending Physiclan: The law requires that the death certificate be executed Exami Hyperlipidemia physician and the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Diabetes Mellitas attending p for use as t 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) 1 □Yes 2 □No this certificate has been signed by the al director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Abdominal Aortic Aneurysm Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (SpecifyLiving Facil Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only опе) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D35579 August 18, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar Susan J. Miller, M.D.

AUG 26 2009

31. Date filed (Month, Day, Year)

Registrar's Signature

32.

8218 Wisconsin Avenue #305, Bethesda, Maryland 20814

			for State C 1 - State Registrar	of Maryland /	Certificate	of Health and I		ene 2009	27305
I	Physici /Medic		Decedent's Name (First, Middle, Last) YVETTE	S	HE	/MAN	2. Date of Death Month AUGUST	^D 22 2009	3. Time of Death 6:22P M
	Examir		4a. Facility Name (If not institution, give street and no			own, or Location of Death	1	4c. County of Death	
and the second	<u></u>		SEASONS HOSPICE @ NORTHV 5. Social Security Number 6. Sex	7. Age (In yrs. last I		VDALLSTOWN Year If Under 24 Hrs.	8 Date of Birth	BALTIMOF 9 Birth	
	Funeral Director		121-20-1339 1□ M 2 💢 F	79		Days Hours Min.	8. Date of Birth (Month, Day, 05/23/	1930	place (State or Foreign ntry) NY
	land ow		10a. State 10b. County	10c. City, To	wn or Location				10d. Inside City Limits
	death with the Maryland	ctor	MD BALTIMORE		BALTIMORE				1 ☐ Yes 2 X No
	or 28	Ojre	10e. Street and Number		10f. Zip (Code	10	og. Citizen of What Cou	ntry?
	s 23a	ral	7510 PRINCE GEORGE ROAL			21208		USA	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be nutified at once.	by Funeral Director	Armed F	2 X)No ive	13. Was Decede If Yes, specif 1 □ Yes 2	nt of Hispanic Origin? (S y Cuban, Mexican, Puert ☑ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White, Specify: WH]	etc.
5-0	72 h "natu	letec	15. Decedent's Education (Specify only highest grade completed)	16	Sa. Decedent's Usual (Give kind of work	Occupation done during most of wor retired)	king	16b. Kind of Business/Ir	ndustry
121	within ene. than	Completed by	Elementary/Secondary (0-12) College (1-4or 5+)	VICE PRE			APPRAISAL (ROHP
d 2	filed I Hygi other ent,	Be	17. Father's Name (First, Middle, Last)		7102 110		ne (First, Middle, M		311301
Maryland	ould be f Mental larked of	일	NORMAN	HINDLI	N	REBEC	CCA	EDIS	3
lar)	2 sho and l is ma	1 8	19a. Informant's Name/Relationship (Type. Print)			Street and Number or Ru			
	1 and Health em 27 ther to	1.5	LESLYE HEYMAN / DAUGHT			CE GEORGE RE		MORE, MD 21	
Baltimore,	Pages treet of trant: If ite		1 M Burial 2 ☐ Cremation 3 M Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State FORE		08/25	5/2009	NORFOLK, \	/A
Bal	permit. Departi Imports any inji		21. Signature of Funeral Service Licensee		22. Name and 8900 RE	Address of Facility SC	NL LEVINSORD., PIK	ON & BROS., ESVILLE, MI	INC. 21208
			23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on	caused the death. Deach line.	o not enter the mode	of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
- Aug	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Encepho	6 pathy				Onset and Death
-	Examiner		Due to	(or as a consequenc	e of)t				
		Je.	Sequentially list conditions, if any, leading to immediate b. Due to	(or as a consequenc	e of):				
	tificate be executed g physician and as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Et of Underlying Cause (Disease or injury that initiated events						
90,	cate be execu physician and the burial-tra	E	resulting in death) Last Due to	(or as a consequence	e of):				
68760,	physi physi the b	edical	d						
.O. Box (To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as:	Physician/Me	in the past 12 months?	tcome of pregnancy birth 2□Fetal dea nant at time of death nown				23d. Date of deliv	very Day Year
S, P.	ires that signed b	by Pl	Part II. Other significant conditions contributing to o	eath but not resulting	in the underlying cau	se given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ord	equire sen si	ted t					1 ☐ Ye	s 2 □ No 3 □ Pro	bably 45 bnknown
al Records,	ding Physician: The law requinn. n. After this certificate has been si funeral director, page 2 should I	Completed	,				24a. Was an autopsy perform 1 □ Yes 2	y prior to co	opsy findings available ompletion of cause of 2 □ No
of Vital	sician certif rector	Be	25. Was case referred to medical examiner? Hospital:			Other:	th (Check only one		
o	g Physer this eral di	7: To	27. Manner of Death 28a. Date	of Injury 28b	Outpatient 3 DOA	4 ☐ Nursing H c. Injury at Work?	ome 5 Resider		hospice
ion	ath. r: Afte e fune	atio	Natural 5 ☐ Pending (Mor 2 ☐ Accident investigation	th, Day, Year)	Injury M	Work? 1 □ Yes 2 □ No			4 20
Division	al or Atte s after de l Directo	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place build	of Injury - At home, ing, etc. (Specify)	farm, street, factory, o	office	28f. Location (Str City or Town,	reet and Number or Rui , State)	ral Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier Check only one) Check only and mar	e best of my knowled pasis of examination a ner stated.	lge, death occurred a and/or investigation, i	the time, date and place n my opinion, death occu	e, and due to the ca arred at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier		29c.	License number	29	d. Date signed (Month	, Day, Year)
			May Milli	ans	D	47683		8/23/09	
7			30. Name and address of person who completed cau	se of death (Item 23a	i) (Type, Print)	. U		. 2 /	
	Sta	te	Raysond Miller 25 Man 34 Date filed (Month, Day, Year) 32. F	Registrar's Signature	ite Zoo	Remarkowa	no 21	136	
	Registr		Rayand Milk 25 Man 31 Date filed (Month, Day, Year) AUG 26 2009	Denun 1	1. factor	1			

	State of Maryland / Department of Health and State of Maryland / Department of Health and Certificate of Death	d Mental Hygiene					
ician dical	Decedent's Name (First, Middle, Last) HILDA MARTE HEROLD	2. Date of Death Day Year 3. Time of Death August 19, 2009 7:45 PM					
niner al	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of D. 4c. City, Town, or Loc	ice Hartord					
-	Usual Residence of Decedent 10a. State	10d. Inside City Limits 1 ☐ Yes 2 M No					
Director	Maryland Harford Fallston 10e. Street and Number 10f. Zip Code 2615 Lawson Road 21047	10g. Citizen of What Country? U.S.A.					
by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 4 Divorced 1 Yes, Give 1 Yes, Give 1 Yes 2 No Specify:	? (Specify Yes or No- 14. Race - American Indian,					
Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4or 5+) Homemaker	working Own Home					
To Be C		18. Mother's Name (First, Middle, Maiden Surname) Marrie M. Kurtz					
	Virginia M. Stevenson (Daughter) 2615 Lawson Road, Fallst						
	20a. Method of Disposition 1	Date 20c. Location - City or Town, State gust 24, 09 Glen Burnie, Maryland					
ouce.	21. Signature of Fundral Service Licensee 22. Name and Address of Facility MCULLy-Polyniak Fune 237 Fast Patapsco Ave	eral Home P.A. enue, Baltimore, Maryland 21225					
dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):						
Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes * 2 No 9 Unknown 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	23d. Date of delivery Month Day Year					
b	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown					
Completed		24a. Was an autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No					
Certification: To Be	1 Yes 2 No Nursing Home 5 Residence 6 Other (Special North Nor						
Medical Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and proceeding the control of the basis of examination and/or investigation, in my opinion, death and manner stated.						
Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (1/0						
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Hale, Malaloza					
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature	11.00					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** MALLIIW HUBER SR. W. 24, 2009 3:15 p August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 309 Phelps Avenue Arundel Glen Burnie Anne 8. Date of Birth (Month, Pay Year) Nov. 1,1935 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**X** M 2□ F 217-32-7643 73 Nov. Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 No Director Glen Burnie Anne Arundel Maryland 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21060 U.S.A. 309 Phelps Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. 1 ☐Yes 2 No If Yes, Give 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by 3 Widowed 4 □ Divorced Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Paramount Packing & I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Managing Director Rubber Inc. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hunt Ernest Huber Annette 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 309 Phelps Avenue, Glen Burnie, Maryland 21060 James Huber (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Aug. 29, 2009 Glen Haven Mem. Park Glen Burnie, Maryland 21. Signature of Funeral Service Licenses Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ypertensire Cardiovasu **Physician** /Medical e o (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical the as attending IF FEMALE for use If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 ☐ Other (specify) detached g | Unknown signed by Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 4 VInknown 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 s autopsy performed? res 2 No 1 ☐ Yes 1 ☐ Yes To the Hospital or Attending Physician: After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one, Be examiner? Other: 4 Nursing Home 1 ☐ Yes 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Division 1 Natural 1 ☐ Yes 2 ☐ No death. ours after death.
neral Director: # 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my onlines, death account at the cause(s) and manner as stated. within 24 hours a 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signatu leted cause of death (Item 23a) (Type, Print) RZ Pasadona, Mary

State Registrar Ze

01 al

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth Month 3. Time of Death Year **Physician** JOHNSON ELIZABETH 5:00 AM 3,2009 CORENCE AUGIST /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Neme (If not institution, give street end number) Examiner BALTIMORE AVE. 23 N. FULTON If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)

MARYLAND 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) **Funeral** Davs Months Hours 1 □ M 2 5 F 217-01-7668 102 Director Usual Residence of Decedent filed within 72 hours efter death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b County 10a State 1 Yes 2 □ No BALTIMORE Funeral Director MARYLAND 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number ō 1).S.A 238 \mathcal{M}_{i} 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 1 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Maritel Status 1 Never Married 2 Married th end Mentel Hygiene.
7 ie marked other than "naturel", or treumatic event, the Medical Exami Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: BLACK þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elementery/Secondary (0-12) PRIVATE DOMESTIC HOMES 7TH CORADE 18. Mother's Name (First, Middle, Maiden Surname) かんしい KNG いいん 17. Father's Neme (First, Middle, Last) Be Peges 1 and 2 should be JULIA RODGERS HARRY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (DAUGHTER) 23 N. FULTON AVE, BALTIMORE, MD 21223 or other tre ELAINE PAUL 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 08/19/2009 BALTIMORE, MARYLAND Department of important: if any injury or MRK 4 □ Donation 5 □ Other (Specify) IN LEMORIAL 22. Name and Address of Facility
50SEPH H. BROWN JR. FUNERAL HOME 21. Signature of Funeral Service Licensee 2140 N. FULTON AVE, BALTIMORE, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death h sician /Zheimer's */Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner or Attending Physicien: The law requires that the death certificate be executed burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, that initiated events resulting in deeth) Last Due to (or as a consequence of) the 23b. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 SUnknown 1 ☐ Yee 2 ☐ No pertension 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 2 1 ☐ Yes 2 ☐ No 1. Vas 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: To Other: 1 ☐ Yes 20 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred 27. Manner of Death Medicai Certification: Injury et Work? After 1 Natural 2 Accident 5 Pending death. investigation efter death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) filled in by 4 - Homicide o the Hospital within 24 hours of To the Funerei 4 Sectifying Phyeiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner steted. 29a. Certifier (Check only 29d. Date signed (Month, Dey, Yeer) 29b. Signature and title of certifie 29c. License number HO044296 ugost 20, 2009 30. Name end address of person who completed cause of deeth (ttem 23a) (Type, Print) Digital Drive, MD 21090 hute 6 Gothiam \$2. Registrar's Signature 31. Date filed (Month, Day, Year) parker State AUG 26 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** TONES 2009 PAUL AUGUST /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE RANDAUSTOWN VORTHWEST HOSPIMU CENTER Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 0.3.30 . Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours Davs 1**X**M 2□ F Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a State 10h County 28a-f show other traumatic event, the Medical Examinar rest by routhland at 1 ☐ Yes 2 No Baltimore MID GWYNN Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö USA Road Kestor 23a Funeral death v 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) items ? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 XYes 2 ☐ If Yes, Give Year or Dates: 2 □ No 1 □ Never Married 2 □ Married 6 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced 'natural", Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bethlehem Steel Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Ma once. Elementary/Secondary (0-12) College (1-4or 5+) Worker 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name First, Middle, Last) Be CISIE amuel Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Avenue Apt. H Batho MD 21206 Uncell Jones 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Owings Mills, MD Garrison Forest 22. Name and Address of Facility $\sqrt{24}$ gan C. Greene Fungal Sucs 21. Signature of Funeral Service License Road Randall stown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Immediate Cause (Final **Physician** Bowel coloration disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Right A Due to (or as a consequence of): Anastomatic Simplentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached in 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 1 XYes 2 □ No 1 X Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and till

30. Name and address of

31. Date filed (Month, Day,

OLD

ANDALLSTOWN

person who completed cause of death (Item 23a) (Type, Print)

KOAD

32. Registrar's Signature

00060293

MD

2009

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AUGUST

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month 0415 M Jones are us t Raphael 2009 Vernon 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore Randallstown Seasons Hospice If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 05 23 Birthplace (State or Foreign Country) Social Security Number Year) Months Hours Days **№** M 2 🗆 F MD 219-38-2694 67 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State 1 Yes 2 □ No Baltimore MD NA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21207 5024 Belle Ave 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 If Yes, Give 1 XNever Married 2 ☐ Married Black 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Ye ar or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Company Electrician 12th grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gladys Spencer Alvin Jones 19a. Informant's Name/Relationship (Type. Print) Daughter 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Cedarburg Ct. Apt F, Parkville, Md 21234 Robin Jones-Straiten 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4☐Donation 5☐Other (Specify) Baltimore, Md 8/27/09 On-Site 22. Name and Address of Facility
March F/H West 21. Si vature of Funeral Service Licensee 4300 Wabash Ave, Baltimore, Md 21215 23a. Parti. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Metastanc disease or condition resulting in death) Due o (or as a consequence of): Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) SIASONS HOSPICE 1∐Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Examiner The law requires that the death certificate be executed burial-transit physician sthe burial Box 68760, the attending p 0 signed by to ۵. Division of Vital Records, cate has l page 2 s this certificate the Hospital or Attending Physician;

Examine Physician/Medical þ Completed Be ၉ After thi Certification: n 24 hours after death. he Funeral Director: # pletely filled in by the fr after death.

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

Completed

Be

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7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Evanturer must be not lifted at

permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene I Important: If Item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Evaninar must be notee.

Physician

/Medical

Baltimore, Maryland 21215-0036

Medical

State Registrar

and manner stated.

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Old Cart Road ton 5400 Obvan 32. Registrar's Signature

29b. Signature and title of certifier

29a, Certifier

within 2 the

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 11.50 PM Joseph Leon Johnson 2004 AUGI /Medical 4c. County of Death 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE HOSP AGNES ITAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 21.7-38-2706 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 68 Months Days Hours Min. 1 M M 2 □ F 3] Director 1940 Aug Balto. MDUsual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Italian Examiner must be notified at once. 10c. City. Town or Location 10d. Inside City Limits 10a State 10b County Yes 2 □ No Director Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 U.S.A. 6439 Lehnert Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1♥1Yes 2□No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify. Specify: Black 3 ☐ Widowed 4 X Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore Gas and Elementary/Secondary (0-12) College (1-4or 5+) Supervisor 12th grade Electric Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Estelle Smith Frederick Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sister 6441 Lehnert Street, Baltimore, Md 21207 Jeannette Grace Pretty 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Ponation 5 ☐ Other (Specify) Garrison Forest Owings Mills, Md 8/31/2009 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, 21. Signa ur of Funeral Service License baltimore, Md 12 0 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart burne. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SILLAR CANGER 6 Months ON /Medical Due to (or as a consequence of) Examiner EPS1 Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit requires that the death certificate be exect Due to (or as a consequence of). Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) P.O. 9 Unknown signed be be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed 2 1No of Vital 1 □Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation death. 1 ☐Yes 2 ☐ No 2 Accident after death completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier BENKAOUANE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V BENRAOUANE No 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Ye ar Month **Physician** 2009 Marie Warner Jaeger August 22, 8:35PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** <u>Suburban Hospital</u> Bethesda If Under 24 Hrs Montgomery 8. Date of Birth (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** Days Months 1 □ M 2 🗓 F Hours 91 Director 145-50-1535 June 19, 1918 New York Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, tre Modical Evanting mout to motified at 1 ☐ Yes 2 No Director Maryland Montgomery Kensington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 3618 Littledale Road #313 20895 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify: à Specify: 3 X Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be finand Mental F ပ Catherine Kelly Frederick George Warner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum Mary Elizabeth Jaeger/ Daughter 4231 47th Street N.W., Washington, D.C. 20016 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 🗆 Burial 2 🕅 Cremation 3 🗆 Removal from State August 25, 2009 Crematorium 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy, Chaseas Inc., 7557 Wisconsin Avenue 21. Signature of Fundal Service Licensee Bethesda, Maryland 20814-3501 M00335 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** NEUMO disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Liter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) aftending physician and for use as the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 mon Day Year 5 Other (specify) the detached 9 Unknown certificate has been signed by rector, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐Yes 2 ☑No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🖺 No 1 Ninpatient After this c funeral dire Medical Certification: To 1 ☐ Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27, Mann of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Matural neral Director: A filled in by the fr 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

V Oj

State

DHMH 17 Rev 1/2001

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

parke

8218 WISCONSIN AVE

126259

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Day Year Month August Physician 1:44PM lannette Kane-Smith 2009 /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner Randallstown Baltimore Hospice -Northwest easons If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months 1 □ M 2 F Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show wher traumatic event, the Medical Examiner must be realled at MD Ra Himore Yes 2 No Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21207 Springdale Avenue 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 | Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Black 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Consumer Rea. Afairs 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Honzo rances Rello ane Hardwick ပ 19a. Informant's Name/Relationship (Type. Print) Husbard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) E Avenue 3altimore NO 21207 4410 Seringdale : If item 27 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 Burial 2 ☐ Cremation 3 Removal from State permit. Page Department of Important; If any injury or once. Memorial Park 29/09 Windsor Mill, MD 08 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee C. Greene Funeral Kodd Kandallstown, MD 21133 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such at cardiac or respiratory arrest, shock, or heart-failure. List only one cause on each line. Immediate Cause (Final **Physician** Metastatic LUNG disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or uderlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): Box 68760, physician Physician/Medical attending properties as IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year 5 Other (specify) P.O. the detached 9 Unknown à signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed' 1 □Yes 2 No 1 ☐ Yes 2 No Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 5 □ Residence 6 □ Other (Specify) Hospital: Other: 4 \sum Nursing Home 1 □ Yes 2 🖪 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To hospill 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural Division 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide the Hospital within 24 hours a 29a. Certifier Medical 1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, AUG 26

nokujapalne M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

aparse, M.D

25 Main St. >

32. Registrar's Signature

29c. License number

Suite

D0057465

8 24 09

200, Reisterstown, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 1740 M 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day 25) MONEGOMETEX Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗗 F Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ortant; if item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Nortical Examinations and injury or other traumatic event, the Nortical Examinations. 1⊈ Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 ☐ Never Married 2 Married 1 ☐Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify. ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi permit. Pages 1 and 2 should be Department of Health and Menta Important; If item 27 is marked on any Injury or other traumatic ev KIM ပ 19a. Informant's Name/Relationship (Type. Print) #05 beta 10 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Approximat Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) holangucarcinoma **Physician** /Medical Due to (or as a consequace of): 1 months Examiner Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) P.O. Box 68760, the attending physician hed for use as the burial The law requires that the death certificate be Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a Was an has certificate 2 No 1 □Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) this c Hospital: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi funeral of 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 2 Accident 5 Pending investigation 1 ☐Yes 2 ☐No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

the

State Registrar 29b. Signature and title of certifier

Byoung 31. Date filed (Month, Day, Year)

AUG 26 2009

29d. Date signed (Month, Day, Year)

13000 Georgia Ave Silver Spring

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

09-06503 Christopher Kirk Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

hristopher Kirk	State of Maryland / Department of Health and Mental Hygiene - For State Certificate of Death Reg. No.	2731
Physician/	egistrar 2. Date of Death 3. Time	of Death
ledical Examine	Christopher hir August 20, 2009	9 hrs
	ta. Facility Name (if not institution, give/street and number) Northwest Hospital 4b. City, Town, or Location of Death Baltimore 4c. County of Death Baltimore County	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYYY) 9. Birthplace (Spreign	State or
Director	217-942801 12M 2 F 39 Yrs. Months Days Hours Min. 08-10-1970 Country)	V
any	Usual Residence of Decedent 10c. City, Town or Location 10d. In 10a. State 10b. County 10c. City, Town or Location 10d. In	side City Limits
8 4		Yes 2 No
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene, 15's marked other than "natural", or items 23a or 28a-f show haite event, the Medical Examiner must be notified at once.	10e. Street and Number 10g. Citizen of What Country?	
23a or notifie	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	an, Black,
or items 23	Armed Forces? Never Married 2 Married 2 Married	o U
s after d	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: Specify:	
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5-0036 ed within 72 hour lygiene. other than "nate he Medical Exa	Miller Pipeline Corporation Construct 18	
21215-0036 uld be filed within 72 hours after Martal Hygiers and wateral Hygiers cevent, the Medical Examiner. To Re Commissed by B	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	
2121 2121 wild be fill Mental II marked c event,	19a. Informant's Na elationship (Type, Print) 19b. Mailing Address (StreeLand Number or Rural Route Number, City or Town, S te, Zip Co	ide)
e, MD 1 and 2 sho Health and item 27 is	Da Neece Kirk, Wite 772 6 Big Buck Dr. Windson Mill M.	1) 21244 State
<u> </u>	1 Burial 2 Cremation 3 Removal from State crematory or other place)	\checkmark
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other to	4 Donation 5 Other Specify: 2/ Siz hature of Funeral Service Licensee 2/ Siz hature of Funeral Service Licensee 2/ Siz hature of Funeral Service Licensee	e
Balti permit. Departm Imports injury o	ALLA I HOW II I HOOD LIBERTY HEALT AN BETTO INTO	2007
Physician /Medical	failure. List only one cause on each line.	oximate Interval veen Onset and Death
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	Sequentially list conditions, b.	·
led nisit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	
led nisit	events resulting in death) Last Due to (or as a consequence of):	
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Box 6876(e death certificate the attending phy ed for use as the	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	
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Dipospital bours a uneral I	4 Homicide (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician to the Funeral Director: After this certificate has been signed by the attending physician for the funeral director, page 2 should be detached for use as the best of the funeral director, page 2 should be detached for use as the best of the funeral director, page 2 should be detached for use as the best of the funeral director, page 2 should be detached for use as the best of the funeral director, page 2 should be detached for use as the best of the funeral director, page 2 should be detached for use as the best of the funeral director.	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the caus and manner stated.	se(s)
F . E . S	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Date of Certifier)	ay, Year)
	Theodo M. King Tr., m. D.	
XI	30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
Sta	31 Date filed (Month, Day Yoar) 32 Registrar's Signature	
Registra	AUG 2 6 2000 Lenus S. Jake	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Jane Marcelline Kalafos 21, 2009 August 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 11100 Chambers Court Unit A Woodstock Howard 8. Date of Birth (Month, Day, Year) Jan 14, 1932 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Days 1 □ M 2 14F Months Hours 77 216-28-8897 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☑ No Howard Woodstock 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21163 USA 11100 Chambers Court Unit A 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 2 🔀 No 1 Never Married 2 Married White 1 ☐ Yes 2 🛛 No Specify Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Purchasing Specialist Military/Government 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surname) Edward A. Zang Elda Mae Peters 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Kalafos Son 11 Riverview Road; Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State Loudon Park Cemetery | 8/25/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licen 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SMAL NON months Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

and Mental Hygiene.

eq pinous

other t

Important: If it any injury or o

72 hours after

3altimore, Maryland 21215-0036

/Medical

10a. State

MD

Director

Funeral

2

Completed

Be

burial-transit

requires that the death certificate be executed

P.O. Box 68760.

Division or Vital Records,

or Attending

the Hospital

Examiner Physician/Medical þ Completed Be P Certification:

25. Was case referred to medical examiner?

5 Pending investigation

6 Could not be determined

Year)

1 ☐ Yes 2 No

27. Manner of Death

1 Natural 2 ☐ Accident

3 Suicide

29a. Certifier

Medical

4 Homicide

(Check only

31. Date filed (Month, AUG 2

physician the use as t attending for signed by the a d be detached for page 2 should certificate has been After this funeral thours after death. death. filled in by 24 hours a

To the within 2

3□ DOA

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1∐ Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

26. Place of Death (Check only one)

29b. Signature and title of certifier

2 ER/Outpatient

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE MO 21229

32. Registrar's Signature

1 Inpatient

28a. Date of Injury (Month, Day Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #25, per ME 8894 8/26/09 TT State of Maryland Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009 Year Month **Physician** August 5:30 A M Kate Elizabota Kibbe /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 17005 Overhill Road Montgomery Derwood 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs, last birthday) **Funeral** Months Days Min. Hours 219-57-5418 9 June 19, Director 2000 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits show 7 Is marked other than "natural", or items 23a or 28a-f shor traumatic event, the "dealfeal Event net must be notified at Maryland Montgomery 1 ☐ Yes 2 X No Director Derwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17005 Overhill Road 20855 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White ρ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Student Elementary School 3 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Martin Joseph Kibbe Donna J. Walter ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 Is any injury or other trau once. Martin J. & Donna J. Kibbe/Parents 17005 Overhill Road, Derwood, Maryland 20855 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date August 1 Burial 2 □ Cremation 3 □ Removal from State Dorchester Memorial Park 2009 Cambridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Survice Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Mysfette Bans w M01305 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card ac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 000 Immediate Cause (Final Physician Due to (or as a const uence of): disease or condition resulting in death) /Medical Examiner uncertain Due to (or as consequence Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (DISEASE OF INJULY that initiated events Examiner consequence of but within attending physician and for use as the burial-transit mu como bolle resulting in death) Last Due to (or as a consequence of) munutes 4 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 🛛 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by anomoles CNS 2 No 3 Probably 4 Unknown been si should t 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an certificate has autopsy performed? 3) Plyure disorde within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\sum \) Nursing Home 1 Towns 2 1 1 100 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

Hospital or Attending

death v

Pages 1 and 2 should be filed within 72 hours after

certificate be executed

P.O. Box 68760,

Division of Vital Records,

Baltimore, Maryland 21215-0036

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PEORIERA

neuro

29b. Signature and title of certifier

19251 MONTCOMERY VILLAGE AVE, MONT, VILLAGE, MD 20886
Registrar's Signature parks

P001004

29d. Date signed (Month, Day, Year)

810.09

29c. License number

State Registrar

			1 - For State Registrar	State of Ma	ryianu / L	•			eailtí ai Death	IU IVI	-	Reg. No		
П	Physici	an	1. Decedent's Name (First, Middle, Last) Catherine Ma		la i valei						2. Date of De Month	Da		3. Time of Death
1	/Medic		4a. Facility Name (If not institution, give		DIUSKI	4	4b. City.	Town, or	Location of I		August		23 2009 County of Death	8:35 A.M
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	Funeral Director		213 10 0170	7. Age	(In yrs. last bir	A	If Under Months	1 Year Days	If Under 24 Hours	Hrs. Min.	8. Date of Bir (Month, Da 1/12/1	th ly, <i>Year)</i> .921	9. Birth Cou Balt	place (State or Foreign intry) Maryland
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Locat	tion							10d. Inside City Limits
Maryla f sho	Maryla -f sho	tor									1 ☐Yes			
	or 28a	Director	10e. Street and Number	<u></u>].		T	10f. Zip	Code				10g. Çi	tizen of What Cou	intry?
	ath wit		1415 Overlook Wa	ıy				2101				(of Ameri	ca
980	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it is Madical Evaminat must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ∐Yes 2 No If Yes, Give Year or Dates:			as Deced ′es, sped]Yes :		spanic Origir n, Mexican, i Specify:	n? (Spe Puerto F	cify Yes or No Rican, etc.)	-	14. Race - Amer Black, White Specify:	
21215-0036	n 72 hou "natura edical E	Completed	15. Decedent's Edu (Specify only highest grade			Deceder	nt's Usua	al Occupa rk done d	ition uring most o	f workin	g	16b. K	(ind of Business/In	ndustry
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nd	be filed tal Hy d othe event,	Bec	17. Father's Name (First, Middle, Last)								(First, Middle		Surname)	
Maryland	should be and Mental marked c	၉	Patrick J. 19a. Informant's Name/Relationship (Ty.								. Stre			
	and 2 sl ealth an n 27 is n		Maureen A. Bandeli										or Town, State, Z yland 21	
Baltımore,	es 1 a of Hea fitern rothe		20a. Method of Disposition		20b. Place o cemete Gall'18	f Dispositi	ion (Nan tory or o	ne of ther place	9)		ate	20c. L	ocation - City or T	own, State
Ĕ	t. Pages tment of tant: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		Vetera	ms C	emet	ery	- 1	200				rest, MD
Ba	permit. Pages Department of Important: If it any Injury or once.		21. Signatur of Fun ral Service License	ie .									&Cremat Maryland	ion Ctr.,P.2 21093
		3	23a. Part 1/Enter the disease, or complished, or heart failure. List only or	cations that caused the cause on each line	the death. Do	not enter	the mod	e of dyin	g, such as ca	ardiac oi	respiratory a	rrest,		Approximate Interval Between Onset and Death
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			IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome o	f pregnancy							J	23d. Date of deli	
The law requires that the death certificate be executed		Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	11 II ive hirth 21 Fetal death 31 Fetonic pregnancy							Day Year			
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- '		e Co	Rheumalt: 1 And 25. Was case referred to medical	ri.hs					00 Plans	6 D 15	1 □ Yes	2- No	death? 1 ☐ Yes	2 □No
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יו סד	ing Pr	ion: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day,	Year) 28b.	Time of njury		8c. Injury Work	at ?	2	8d. Describe			,,
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	vithir To th comp	Me	29b. Signature and title of certifier				290	. License	number			29d. Da	ate signed (Month	, Day, Year)
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			30. Name and address of person who co					A	re 73	212	MARIA	m.	0 2126	4
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar		1	. 6	- '	100	·			7 ~126	6

Registrar

parker

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 35 PM Medical 4b. City, Town, or Location of Death County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** MOK If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗹 Months Days Hours Min nth, Day, NEW JERSEY Yrs Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 🗌 Yes 2 🖫 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 61 death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No WHITE Specify: Specify: and Mental Hygiene. 3 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) PHYSICIAN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ARM ROAD GLEN ARM. MU 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 🗆 Burlal 2 🗹 Cremation 3 🗆 Removal from State PUNSPAL CHAPELAIR AUGU 4 Donation 5 Other (Specify) PHRKVIUE IN SERVICE Signature of Funeral Service Licenses ROAD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or all a consequence of Examiner 2 Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innerial director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 menths?

1 Yes 2 No Month Vear Day 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of his certificate has b I director, page 2 sh autopsy death? perform Yes 2 N 2 🗌 No 1 🗌 Yes **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 28a. Date of injury (Month, Day, Year) 27. Manner of De th 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate; Natural 5 Pending work' 1 🗌 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 6701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

amend #10 c, 13, 16 acb, 20 a - c 22 Pack Indelible light Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Are Legible.

		1 - For State Registrar	State of Maryla			te of D			Reg. No.	2009	27320	
Physic	ian	1. Decedent's Name (First, Middle, La						Month August	Day 13	2009°	9:30 A M	
/Med		George Collins La 4a. Facility Name (If not institution, giv.			4b. City	. Town, or I	Location of Death			County of Death	3,30	
Exami	ner	95 Dawson Avenue				ckvil			N	Montgomery		
Funera Director		5. Social Security Number 6. S	ex 7. Age (In yrs	i. last birthday)	If Unde Months	Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Feb 8,	y, Year)	Cou	place (State or Foreign ntry) yLand	
pu 🛦		Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Lo	ocation						10d. Inside City Limits	
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the N	rect	MD Montgo 10e. Street and Number	mery	DIIVO		p Code			10g. Citiz	en of What Cou	ntry?	
3a or	ō	95 Dawson Avenue	#301				20850			USA		
ING Z1Z13-UU3O be filed within 72 hours after deeth with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show svant, its Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates.			edent of His ecify Cuban 2X No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		4. Race - Ameri Black, White, Specify: b]		
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Dhusisian		23a. Part I. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	plications that caused the de one cause on each line.	ath. Do not en	ter the mo	de of dying			rrest,		Approximate Interval Between Onset and Death	
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Geath certif	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)						2	23d. Date of deliv Month	very Day Year	
dS, P.O.	þ	Part II. Other significant conditions	contributing to death but not re	esulting in the I	underlying	cause give	n in Part I.		obacco u Yes 2[the cause of death?	
VITAI HECOTGS, sician: The law requires t certificate has been signe irector, page 2 should be of	Completed				-			24a. Was auto perio 1 Yes		24b. Were aut prior to co death? 1 \(\text{Yes}	opsy findings available ompletion of cause of	
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Of V Physic r this c	ပို	1XYes 2□No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Home 5 Residence 6 Other (Spec								ıfy)	
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the I	Medical	29b Signature and title of certifies	and manner stated.		2	9c. License	number		29d. Dat	e signed (Manth	, Day, Year)	
5 <u>₹</u> 5 Ø		250. Signature and title of certified	00//	2 02	6	15 -	3 - of 5 C		A	رد از م در از م	9 (A=29	
		Stow 1	completed cause of death (om 23a) (Tuan	C Price)	1.) =	10/10	mable		Porte	15	
		30. Name and address of person who 31. Date filed (Month, Day, Year)	RECUTATION OF THE RESERVENCE O	DOD O	, Print) かた	6	1401	3000	W.	man	10900	
	tate	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature -		11	1001	Jan.	/	0.50	20,02	
Regis		AUG O G ON	10 /2	1 /20	A Read	,		_				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Month **Physician** 7:24 PM 20001 .009 August 20 *saymona* /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Smai Baltimore 9. Birthplace (State or Foreign Country) Hospital Baltimore OF If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1 M 2□F 249-38-317 North Cartina Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County items 23a or 28a-f show iner must be notified at 1 Dyes 2 □ No Baltimore Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Virginia 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. other traumatic event, the Medical Examiner filed within 72 hours after 1 Never Married 2 Married 1 Yes 20 No If Yes, Give Year or Dates: ō 1 ☐ Yes 2 No Specify: Blac Specify Completed by 3 ☐ Widowed 4 ☐ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) onstruction +1 HCi 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental h Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rufal Route Number, City or Town, State, Zip Code) Ave, Foo. Ita Health sem 27 i daughter 1410 21224 -uzerne 20a. Method of Disposition

1 Burial 2 □ Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 ō Department of Important: If it any Injury or o 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Heichts 4600 Balto Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or ma piratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician urknown disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year signed by the at d be detached fo 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy performed? Yes 20 No certificate Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2₹No 2 PER/Outpatient 3 DOA 1 Inpatient Certification: To this 27. Manner of Death the funeral 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident or Attending (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 Homicide To the Hospital within 24 hours a

To the Funeral I 1 > ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and itle of certifier 30. Name and address of pers who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) AUG 2 6 2009 32. Registrar' Registrar

Baltimore,

Division or Vital Records, P.O. Box 68760,

permit. Pages
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Important: If it
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item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the "motical Exemiting must be recified at

hours after

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Pages 1 and 2 s ment of Health ar ant: If item 27 is

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physician and the burial-transit ası the attending nse jo signed by the peen has page 2 certificate After this of funeral dire

the death certificate be executed

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Records,

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the Hospital or Attending Physician; The

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within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

CONGESTIVE 25. Was case referred to medical examiner?
1 Yes 2 ☐ No 27. Manner of Death 1 Matural 2 Accident 3 ☐ Suicide 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

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State Registrar

DHMH 17 Rev 1/2001

30. Name and advices of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

TABASSI, year) G 26 2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 13, 2009 ar **Physician** Ti Ming Lin 10:22 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth May 6, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1**x** M 2□ F Months 92 215-17-5002 China Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinar must be a collised at 1 ☐Yes 2X No Director Maryland | Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10217 Shining Willow Drive 20850 United States Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after 1 □Yes 2 No 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Asian Specify. \$ 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental it of Health and Menta Li Fu Lin Zi Wan Song 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Xue Zhen Jin/ Wife 10217 Shining Willow Drive, Rockville, Maryland 20850 other i 20b. Place of Disposition (Name of Cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 20c. Location - City or Town, State 20a. Method of Disposition Date injury or permit. Page Department of Important: If any injury or once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State August 23, 4 ☐ Donation 5 ☐ Other (Specify) 2009 Bethesda, Maryland 22. Name and Address of Facility Robert A. Bethesda-Chevy Chase Bethesda, Maryland 20814. Pumphrey Funeral Home/ . 7557 Wisconsin Avenue 21. Signature of Funeral Service Livense M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acute Myocardial Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (unas a consequence of) the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760 Physician/Medical attending p IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 \subseteq Ectopic pregnancy Day Year 5 ☐ Other (specify) P.O. ☐Yes 2☐No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 autopsy 1 □Yes 2 🔀 No 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗍 Inpatient 2 A ER/Outpatient 3 ☐ DOA this Certification: To 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Attending Injury 1 🛛 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 3 ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 Homicide ö Hospital e Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated within 2 Date signed (Month, Day, Year) 29b. Signature and title of certifle 29c. License numbe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William R. Dooley, M.D. 9901 Medical Center Drive, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 tems 1, 29d per doc 8894 8-26-09 yt State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Calvin T. Lewis Day Physician Year AUGUST 22, 2009 11:13p /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 3235 BURLEITH AVE. N/A BALTIMORE Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Days Hours 1 X M 2 □ F Director 220-20-5555 81 5-30-1928 VIRGINIA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, I'm Matical Examinar must be notified at once. 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location Director 1XYes 2 □ No MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3235 BURLEITH AVE. 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 🛱 No Completed by Specify. Specify: BLACK 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) -12-MAIL HANDLER US POSTAL SERVICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ HERBERT A. LEWIS GEORGIANNA V. THOMPSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THELMA A. LEWIS (WIFE) 3235 BURLEITH AVE. BALTIMORE, MARYLAND 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 14 Burial 2 Crematis 3 Removal from State 4 Donation ARBUTUS MEMORIAL PARK 8-28-2009 | BALTIMORE, MARYLAND 5 ☐ Other (Specify) 21. Signatura Service Licenses ONATHAN D. HIBNER 2. Name and Address of Facility PHILLIPS FUNERAL HOME. P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part i Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediae Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of): Approximate Interval Between Onset and Death Physician /Medical Due to (or as a consequence of): **Examiner** Saque Itially liet or ditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and pipetery filled in by the funeral director, page 2 should be detached for use as the burial-transit maps the pure the pure transit master. a Due to (or as a consequence of): Box 68760 If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 🗆 No 1 🗆 Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 ∏No Other: 4 Nursing Home 52 Residence 6 Other (Specify) 1 ☐ Yes Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Man of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifler (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

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State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

NO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Figistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** PM 5:06 MASON AUGUST 2009 ELOISE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSPINAL CENTER RANDALLSTOWN BALTIMORE NORTHWEST If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 ☑ F Months Days Hours 218-42-4646 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Mexical Examiner must be notified at 1. Yes 2 □ No Baltimore Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 USA Hage Ave Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 2. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? 1 ☐ Yes 2 ☑ No 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Black 1 ☐Yes 2 No Specify. þ Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) and Mental Hygiene. College (1-4or 5+) eachers 150 Himore City Public Schol 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be McCrae Whiting Dernice ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1509 Health em 27 I Collins Ingleside Ave. Baltimore, pub 21207 sortant: If item 27 injury or other to 20b. Place of Disposition (Name cometery, crematory or other 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. ing Memorial Baltimore, MS 4 ☐ Donation 5 ☐ Other (Specify) Greent funeral Samo 21. Signature of Funeral Service License 23a. Part 1. Enter the diseas shock, or heart failure. se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final Physician PHEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner MALHUTRITION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): executed Exami GASTRIC CANCER and burial-tran Due to (or as a consequence of): attending physician law requires that the death certificate be Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown for use 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 5 Other (specify) the detached signed by to be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ LUPUS 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 2 No 1 □Yes 1 ☐Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P. 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No n 24 hours after death.

le Funeral Director: A
pletely filled in by the fu death. 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 🗌 Homicide

Box 68760 P.0. Records, Division of Vital

Maryland 21215-0036

Baltimore,

Registrar

31. Date filed (Month, Day, Year) State AUG

29a. Certifier

(Check only one)

29b. Signature

cal

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AHMED. MURTUZA

5401 OLD COURT ROAD. RANDALLSTOWN MD

and manner stated

Registrar's Signature

the the within 7 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0060293

29d. Date signed (Month, Day, Year)

2009

State of Maryland / Department of Health and Mental Hygiene 🛴 Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Month **Physician** ZI 1730 M Benjamin 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** University of Maryland Medical Center
5. Social Security Number 6. Sex, 7. Age (In yrs. last birthol Baltimore Baltimore N/A If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 F Months Days Hours Director 155-40-1668 Nov 20, 1951 New Jersey Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland lealth and Mental Hyglene. To 7 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f st other traumatic event, the Modical Examination in Affilial Director 1 Yes 2 □ No Anne Arundel Maryland Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 415 Howard Manor Drive 21060 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 197 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1971 1 ☐ Yes 2 ☐ No Specify. 9 Specify: 3 Widowed 4 Divorced Black Year or Dates: 1972 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Woodland Job Corp. Residential Advisor 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be McNe111 Benjamin Mattie McNeill ပ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 is Maria McNeill 415 Howard Manor Drive Glen Burnie, Maryland 21060 permit. Pages 1 a
Department of He
Important: If item
any injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐xBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/28/09 Crownsville, Md. Crownsville Veterans Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility Estep Brothers Funeral Service, P. A.

1309 Eutew Place Baltimere, Md 21217
sho's, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a. nonischemic cardiomyopathi /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a surissiquenes off and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 □Yes 2 🗆 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending investigation hours after death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) NPI Aug. Zi, 2009 1518192368 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Mackenzie Short

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Saltimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records,

32. Registrar's Signature

South Greene St. Baltimore, MD 21201

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Martin Pauline W. 8 15 2009 8:54p.m. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Liberty Heights Nursing & Rehab Baltimore 7. Age (In yrs. last birthday) If Under Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Hours Months Days 1 M 2 M 2 X 30 30 Director 215-28-9607 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1XXes 2 No Baltimore Director N/A MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21201 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 MaNo If Yes, Give Year or Dates: 946 Stoddard Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2√2 No Specify Specify: Black þ ₩Widowed 4 Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8TH GRADE N/A Disabled Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alfred Holmes Pauline Rasin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Carla Freelance- Grand 946 Stoddard Court Balto, MD 21201 daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 8-24-2009 Lansdown, MD Zion Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MARCH FUNERAL HOME-EAST 21. Signature of Funeral Service Licensee Wou 1101 E. North Avenue Baltimore, 23a. Part 1. Enter the disease, or omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ed by the a 1 ☐Yes 2 ☑No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. certificate has been signed rector, page 2 should be del <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 ☐/No 1 🗌 Yes the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 🗌 Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A IAHMED MD & ZI N Eewaw AHMED MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 26 2009 Registrar

/aseem Mushtaq	•	- For State	State	e of Maryland		tment of <i>ificate of</i>		d Menta	al Hygie		No	200	9 2732
Physician		egistrar I. Decedent's Name (I	First, Middle,La	ast)		170010 01			2. Da	Reg.		Year	3. Time of Death
ledical Examine		Waseem					htaq			onth Dugust 25, 2	2009	inty of Death	0558 hrs
	4	a. Facility Name (if no Northwest Ho	-	ive street and number)			4b. City, Town, or Randallstov		Death			more Cou	nty
Funeral Director	- 1	5. Social Security Num	mber 6.		e (In yrs. las		If Under 1 Year Months Day		Min			Foreig	pplace (State or Pakistan
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/ any			b. County		10c. City, T	own or Locat	ion						10d. Inside City Limits
Aaryland 28a-f show 1 at once.	<u>.</u>	MD	N2	Α]	Balti				100	Citizon	of What Cour	1 X Yes 2 No
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	- L	11. Marital Status		12. Was Decedent	Ever in U.S		as Decedent of Hi	spanic Origi	in? (Specify		14. f		can Indian, Black,
death or iten must l	Prine	1 Never Married		1 Yes 2	X No		es, specify Cuba		Риепо кіса	n, etc.)		7.	sian
rs after ural", miner	⋧┞	3 Widowed		ed If Yes, Give Year or Dates: only highest grade con	npleted)		Yes 2 X No		ind of work	done '	Spei	of Business/I	
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5-0036 led within 72 Hygiene. other than	Completed	12th gr		na			Unemplo	_	a Nama /Fire	st, Middle, Ma	idon Surr		oloyed
1215-0036 Id be filed within 72 hou dental Hygiene. Thanked other than "nat event, the Medical Exa	Š R	17. Father's Name (Fi Mushta q								Beegu		iame)	
D 21215-003 should be filed within and Mental Hygiene, is marked other if natic event, the Med	o l	19a. Informant's Name Khan Mus	e/Relationship	(Type, Print) Son Broth	er	19b. Mailin	g Address (Stre	et and Num	ber or Rural	Route Numb	er, City or	Town, State	, Zip Code) Harford
ore, MD es 1 and 2 sho of Health and If item 27 is her traumati	L	20a. Method of Dispo			_		sition (Name of ce		Da	-		tion - City or	
9	1	1 X Burial 2	Cremation			ematory or of Infi	her place)		8/26	/09	Infi	eld,	CT
Baltimo permit. Page Department c Important: injury or ott		4 Donation 5 21 Signature of Fune				Ma ²	Name and Addres	of Facility	t.				
		LRV	ne &	mplications that caused	sur	43	00 Waba	ash A	ve,	Balti	more	or heart	21215 Approximate Interval
Physician / Ledical		failure List only	one cause on					, such as C	ardiac or res	piratory arres	st, 31100K,	or riourt	Between Onset and Death
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	اي	Sequentially list cond if any, leading to imm		b	sequence of)	,							
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certificate be e	ĕ į	IF FEMALE: 23b. Was decedent pr	regnant in the	23c. If yes, outco	me of pregn		etal death 3	Ectopic	c pregnancy			ate of deliver	y Day Year
tox 6876 eath certificate attending phy for use as the	icia I	past 12 months?		4 Pregnant a	t time of dea		other (Specify)		o programo,				
P.O. Box that the death or ned by the atten detached for us	Physician/M	1 Yes 2 No		g Unknown s contributing to dea	th but not re-	sulting in the	underlying cause	given in Pa	art I.	23e. Did tol	pacco use	contribute to	the cause of death?
P.O.	. 1	r are ii. Othor Signific		io dominating to doc	ar par not ro	Juning III 111		J		1 Yes	2 🗸 N	o 3 Pro	bably 4 Unknown
ords, P.C. w requires that is been signed be should be deta	Completed by									24a. Was a		24b. Were a prior to	utopsy findings available completion of cause of
Recol The law	g									perform		death? 1 ✓ Y	
Vital Rec ysician: The his certificate director, page	Be	25. Was case referre examiner?	d to medical	Hospital: Inpati				oe of Death	(Check only				
of Vital Records, ag Physician: The law required the this certificate has been someral director, page 2 should	위	1 ✓ Yes 2 27. Manner of Death	No	I IIIpati		ER/Outpatier 28b. Time of		jury at Work	Nursing H	ome 5d. Describe h	Residence low injury		er:
on of ending Phenath.	<u>ij</u>	1 V Natural	5 Pending		Year)			Yes 2	-				
Division pital or Attendir ours after death. reral Director: A	Certification:	2 Accident 3 Suicide	Investig	28e. Place of I	Injury - At ho	me, farm, str	eet, factory, office	building, e	tc. 28	f, Location (S or Town, S		Number or R	ural Route Number, City
Ospital hours a		4 Homicide 29a. Certifier	determi	(0,000.)/						a to the secue	c(a) and m	nonnor ne etc	ted.
Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phe completely filled in by the timeral director, page 2 should be detached for use as the	Medical	1061	ertitying Phys ledical Exami	sician: To the best of r	amination ar	ge, aeath occi nd/or investig	arred at the time, ation, in my opinio	on, death o	ace, and due ccurred at th	e time, date	and place	, and due to t	he cause(s)
To cor	ğ	29b. Signature and ti	tle of certifier	and manner stated	1.		29c. Licei	nse number					onth, Day, Year)
		0_	m).	<u> </u>			0.0	C.M.E.			Augus	st 25, 200	9
5		30. Name and addres		ho completed cause of Assistant Med			1 Penn Stree	et, Baltim	ore, MD	 21201			
Sta		31. Date filed (Month		32. Registr	ar's Signatu		/						
Registr	ar		AUG 26	2009 2	2112	19. 1	an Had						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State	State of Ma	arylan			nt of H ete of L		ind Me			2000	273	2-0
			Registrar 1. Decedent's Name (First, Middle, Las	t)			lilica	ile Oi L	Jeani		2. Date of De	Reg. No.	JUJ	3. Time of D	eath
п	Physici		Thomas	Lee			Matt:	ion			Month August	Day	Year	1221	М
The same	/Medid Examir		4a. Facility Name (If not institution, give						Location of		1.00 9 0 0 0		County of Deat	h	
فمرب				Jentist t	lospit	al		ocker					untgom	ery	
	Funeral		5. Social Security Number 6. Se 470–38–9799	ex 7.Ag MIM 2□F	e (<i>In yr</i> s. 70	last birthday Yrs.) If Und Months	er 1 Year Days	If Under 2 Hours	Min.	B. Date of Bir (Month, Da August 4	th Year)	9. Birt	hplace <i>"(State or l</i> untry) nesota	Foreign
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900	be filed within 72 hours after death with the Maryland that Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Midfrel Examiner must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 1 If Yes, Give Year or Dates:		5. 13	. was Dec If Yes, sp 1 □ Yes		spanic Ong n, Mexican, Specify:	Puerto R	ify Yes or No ican, etc.)		4. Race - Ame Black, White Specify: Wh		
21215-0036	within 72 h iene. • than "natu the Medical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation de c <i>ompleted)</i> College (1-4or 5 1 -	+)	(Giv life.	e kind of w DO NOT	use retired	urina most	of working	g		d of Business/	ndustry	
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Maryland	short surger		19a. Informant's Name/Relationship (7			T .	-					-	Town, State, 2		
	1 and 2 Health em 27 i		Holley Potter Matt	son/ Wife										yland 20	874
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify.			Place of Disp remetery, cre ntgome mator	ematory`or YV LUM,	other place Inc .		gus t 2009)	Bet	ation - City or : :hesda,	Marvlan	nd
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lio	ee	MO14	198 R	22. Name ockvi	and Addres	s of Facility Inc. Maryl	Robe 300 and	rt A. West M 20850	Pumpl	rey Fu omery A	neral Ho venue	ome/
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused ne cause on each lir	the death									Approximate Interval Betwe	een
	Physician		Immediate Cause (Final disease or condition	a. Brain	Can	cer								Onset and De Months	eath
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Box	death certi e attending id for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 4 ☐ Pregnant at	2 🗀 Fetal	I death 3	□ Ectopic □ Other (:	pregnancy				23	3d. Date of del Month	very Day Ye	ar
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Division of Vital Records,	inding Physath. r: After this ie funeral dii	Certification: To	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injur (Month, Day	ry	28b. Time of Injury		28c. Injury Work		28	3d. Describe			, , , , , , , , , , , , , , , , , , ,	
Divis	tal or Attenc	Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubuliding, etc.	ry - At ho . (Specify	me, farm, st	reet, facto	ry, office		28	Bf. Location (S City or To	Street and vn, State)	Number or Ru	ral Route Numbe	er,
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Medical	29a. Certifier 1 Certifying Phy (Check only one) 1 Medical Exam	rsician: To the best of iner: On the basis of and manner sta	examina	wledge, dea tion and/or i	th occurre nvestigatio	d at the tim	ne, date and pinion, deatl	d place, ar h occurred	nd due to the d at the time,	cause(s) date and p	and manner as place, and due	stated. to the cause(s)	
	To the Within To the comple	Σ	29b. Signature and title of certifier				29	c. License	number			29d. Date	signed (Month		
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	81		30. Name and address of person who o	-	eath (Item			0 0-	uter	De		D 1.	ville, 1	40	
77,757	Sta	e	31. Date filed (Month, Day, Year)	32 Registra	r's Signat		arke	y Ce	WILL	Dri	ve	KOCK	ville,	-11/	
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State

Registrar

31. Date filed (Month, Day,

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32. Registrar's Signature

			State of Maryland / Der	partment of Health and Mer	ntal Hygiene	07001
			_ FOr	ertificate of Death	Reg. No	009 21331
	Dhusisi		1. Decedent's Name (First, Middle, Last)	2.	Date of Death Month Day	3. Time of Death
	Physici /Medio		Fred Prevette			2009 1:40 A. M
	Examir	er	4a. Facility Name (If not institution, give street and number) 1320 Conowingo Road	4b. City, Town, or Location of Death Bel Air		County of Death
	Euperal		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda		Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
	Funeral Director		240–28–3698 ¹ ∑ M 2□ F 89 Yrs.	Months Days Hours Min.	g. 26, 191	19 North Carolina
	pu ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	ocation		10d. Inside City Limits
	laryla f shov	ō	Maryland Harford Bel A			1 □ Yes 2 □ No
	28a-	Director	10e. Street and Number	10f. Zip Code	10g. Citi:	zen of What Country?
	h with		1320 Conowingo Road	21014	Unite	ed States
	ems a	Funeral		B. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ric		14. Race - American Indian, Black, White, etc.
36	s after	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 M No	1 ☐ Yes 2 📉 No Specify:		Specify: White
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Exemine rust be notified at	ed b	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education 16a. December 16a.	cedent's Usual Occupation		nd of Business/Industry
215	hin 72 9. an "ne Media	plet	(Specify only highest grade completed) (Gi	ve kind of work done during most of working . DO NOT use retired)	"	
	filed witl Hygiene rther tha	Completed	8 Truc	k_Driver		nsportation
pu	be de de eve	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (F		Surname)
Maryland	2 should be filed withir nand Mental Hygiene. is marked other than raumatic event, the Mental	မ	Gordon Wilford Prevette 19a. Informant's Name/Relationship (Type. Print) 19b. Ma	Maude Woo iling Address (Street and Number or Rural R		r Town State Zin Code)
Ma	1 and 2 s Health an em 27 is I			Conowingo Road Bel		
re,	S		20a. Method of Disposition 20b. Place of Discemetery, c	position (Name of ematory or other place) Aug. 2	20c. Lo	cation - City or Town, State
im	nit. Pages artment of l ortant: If ite injury or o		4 Donation 5 Other (Specify) BelAir M	em. Gargens 200	9 Bel A	Air, Maryland
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Evans Funeral Chapel	& Cremati	on Service-BelAir
			1au X-CEGULOS	3 Newport Drive Fores	st Hill. M	Maryland 21050 Approximate
	S 5 4 4		23a. Part 1. Enter the disease, or complicitions that caused the death. Do not a shock, or heart failure. List only one cause on each line. Immediate Cause (Final	sitter the mode of dying, such as cardiac of h	espiratory arrest,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	bullation		- gears
	Examiner		$\Omega / \cdot \cdot t$	sein		4000
	pe ##	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			1
	and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C			
760,	icate be executed physician and s the burial-transit	calE	Substitution and defined an interpretation of the			
687			u			
Вох	leath certificat attending phy I for use as the	M/ue	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death	3 ☐ Ectopic pregnancy		23d. Date of delivery
О. В	the att	Physician/Med		5 ☐ Other (specify)		Month Day Year
o.	hat the de ed by the detached		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco u	use contribute to the cause of death?
Records,	Physician: The law requires that the death certifica this certificate has been signed by the attending phral director, page 2 should be detached for use as the	Completed by			1 ☐ Yes 2	No 3□ Probably 4□ Unknown
Ö	w requir s been si should i	lete			24a. Was an	24b. Were autopsy findings available
Be	The law ite has age 2 s	m o			autopsy performed? 1 □ Yes 2 ☑ No	prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
Vital	ysician: The l is certificate hadirector, page	Be C	25. Was case referred to medical examiner?	26. Place of Death (
of V	Physic this coal al dire		1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa		5 Residence	
UC	ding Phy h. After thi funeral	ion:	27. Manner of Death 1 Natural 5 □ Pending (Month, Day, Year) 2 □ Accident investigation 2 □ Accident		d. Describe how injur	y occurred
Division	Attender deatlector:	fical	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm.			d Number or Rural Route Number,
Ω	tal or s afte al Dire ed in t	Certification: To	4 Homicide building, etc. (Specify)		City or Town, State	
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funera	Medical (29a. Certifier (Check only one) Certifying Physiclan: To the best of my knowledge, do not be	eath occurred at the time, date and place, an rinvestigation, in my opinion, death occurred	d due to the cause(s I at the time, date and) and manner as stated. d place, and due to the cause(s)
	To the within To the Comit	ž	29b. Signature and title of certifier	29c. License number		te signed (Month, Day, Year)
			Craig M. Shoughnesse	4.D. D0037078	Aug	ust 21, 2009
			30. Name and address of person who completed cause of teath (Item 23a) (Type	e, Print)	- 0	

State Registrar

State of Maryland / Department of Health and Mental Hygiene

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		1	For State Registrar	State of W		Certificate of			Reg. No.) 4100-
			1. Decedent's Name (First, Middle, L	a <i>st</i>)				2. Date of Dea Month	Day Ye	
	Physicia /Medic	al		inia	Proctor			August	15,2009 4c. County of E	1:45 A M
1	Examin	er	4a. Facility Name (If not institution, g)		r Location of Death	٦	Montgom	
mp.			Manor Care - Pot 5. Social Security Number 6.	Omac Sex 7. A	ge (In yrs. last birth	Potoma day) If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	h 9	Birthplace (State or Foreign Country)
	Funeral Director		577–28–3193 Usual Residence of Decedent	1 □ M 2 🙀 F	_	rs. Months Days	Hours Min.	June 22	1, 1919 Lo	ouisa Virginia
]	land ow		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Mary	흤	Maryland Montgo	mery	Germanto	own				1 Yes 2 No
	or 28s	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	
	ath wi		20909 Scarlett I			20876	Hispanio Origin? (S	Specify Yes or No	United St	ates American Indian,
	items items	Funeral	11. Marital Status1 ☐ Never Married2 ☐ Married	12. Was Decedent Armed Forces 1 □ Yes 2 🔀	?	13. Was Decedent of H If Yes, specify Cub		to Rican, etc.)		Vhite, etc.
21215-0036	within 72 hours after death with the Maryland ene. Han "natural" or items 23a or 28a-f show Modell Evaning to modified	5	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □Yes 2√CXNo	Specify:			Black
2-0	be filed within 72 ho ttaf Hygiene. d other than "natur event, Its Medical	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	pation during most of wor d)	rking -	16b. Kind of Busin	Production
121	within ene. than "	d m	Elementary/Secondary (0-12)	College (1-4or	5+) Cle		u)			deral Gov't
S)	e filed v at Hygie other 1 vent, In		Twe1th 17. Father's Name (First, Middle, La	None st)					, Maiden Surname)	
an	should be that the Mental marked or	To Be	James Carter				L	R. Bel		
Maryland		-	19a. Informant's Name/Relationship	(Type. Print)		Mailing Address (Street				
Σ			Beverly A. Mont	ague/Niece		16 Wedgewoo			nington MI 20c. Location - Cit	0 20744 by or Town, State
a a	0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	☐ Removal from State	e [Disposition (Name of y, crematory or other pla	, –	st 22,		
ţim	permit, Page Department Important: I any injury o		4 ☐ Donation 5 ☐ Other (Special Service Li	cify)	Harmon	y Memorial 22. Name and Addr	200 ess of Facility RO			eral Home Inc
Bal	permit. Departr Importa any inju		21. Signature of Funeral Service Li	Desilar	M Watts	1661 Good				
			23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that cause	ed the death. Do n	ot enter the mode of dy	ing, such as cardia	ac or respiratory	arrest,	Approximate Interval Between
Ι.	Physician		shock, or heart failure. List of Immediate Cause (Final disease or condition	Leukem	iiile.					Onset and Death Years
	/Medical		resulting in death)		is a consequence of	of):				
	Examiner	L	Sequentially list conditions,	b. Anaemia	a	ν.Ε\·.				Years
	ed isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or a	is a consequence of	я).				
	execul and al-trar	xan	that initiated events resulting in death) Last	C Due to (or a	as a consequence of	of):				
68760,	tificate be executed ig physician and as the burial-transit	edical Examiner		d						
			IF FEMALE:						001.5.1	- f - d- li
Вох	death certi e attending id for use a	ian/	23b. Was decedent pregnant in the past 12 months?		n 2 ☐ Fetal death	3 ☐ Ectopic pregnar 5 ☐ Other (specify)	ncy N/A		23d. Date Mont	
0	0 0	Completed by Physician/N	1 ☐ Yes 2 🗷 No 9 ☐ Unknown	9 ☐ Unknowr	t at time of death	5 🗆 Other (specify)				
σ.	requires that the de een signed by the a nould be detached t	/Ph	Part II. Other significant condition	s contributing to death	but not resulting in	the underlying cause g	iven in Part I.			oute to the cause of death?
rds	quires in sign	d be	Failure to Th	rive				. 1]Yes 2 □ No 3	Probably 4X Unknown
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Ä	The law cate has t	S S							formed? de 2X No 1[ath? ☐Yes 2 ▼ No
/ita	Physician: The raths certificate ral director, pag	Be (25. Was case referred to medical examiner?	Hospital:		lo	thor	eath (Check only		(0
of	Phys this ral dir	l:	1 Yes 2 No 27. Manner of Death	1 ☐ Inpa 28a. Date of I (Month,		Time of 28c. Inj	4 La Nursing		sidence 6 Other how injury occurred	
O	Attending Phy r death. ector: After thi by the funeral o	텵	1 X Natural 5 ☐ Pending 2 ☐ Accident investig		Day, Year)		ork? □Yes 2□No			
Division of Vital Records,	i gite	Medical Certification: To	3 Suicide 6 Could n 4 Homicide determi	of be ned 28e. Place of building,	Injury - At home, fa etc. (Specify)	rm, street, factory, office	e	28f. Location City or T	(Street and Number own, State)	r or Rural Route Number,
_	Hospital 24 hours Funeral stely filled	lical C	29a. Certifiler (Check only one) (Check only one)	Physician: To the be xaminer: On the basi and manner	is of examination ar	e, death occurred at the nd/or investigation, in m	time, date and pla y opinion, death oc	ace, and due to the courred at the tim	ne cause(s) and mar e, date and place, ar	nner as stated. nd due to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier			29c. Lice	nse number			(Month, Day, Year)
	. , , , ,		1	ul:		DI	4609		August 1	8,2009
			30. Name and address of person				#202 6 1	ul. ac1	- MD 2007	o
			Raman R. Tuli 31. Date filed (Month, Day, Year)		O Darnest istrar's Signature	own Koad,	#ZUZ,Gait	nersbur	g mu 208/	<u> </u>
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Amend 19b, per FH 9894 8/26/09 TT
State of Maryland Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2009 AUGUST 10:45 PM PRUCE ARLINE Physician/ Medical 4c. County of Death BALTIMORE 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner TOWSON GILCHRIST HOSPICE Birthplace (State or Foreign Country) MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 220-24-5115 . Age (In yrs. last birthday) Funeral Months Days 097197 1925 1 M 2 K F 83 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. Director 1 Yes 2 No BALTIMORE N/A MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21209 Funeral 5503 SOUTH BEND ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No If Yes, Give Year or Dates. 14. Race - American Indian, 1 Never Married 2 Married ģ Specify: WHITE 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 Completed 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) OWN HOME HOMEMAKER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ROSE HOFFENBERG **JACOBS** မ **GEORGE** W 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2005 SOUTHERN AVENUE, BALTIMORE, MD 21214 19a. Informant's Name/Relationship (Type, Print) JUDY FUNK / DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition ANSHETY, EMUNTAH other place) 1 💢 Burial 2 🗆 Cremation 3 🗆 Removal from State 08/24/2009 BALTIMORE, MD 4 Donation 5 Other (Specify) AITZ CHAIM SOL LEVINSON & BROS., INC. 22. Name and Address of Facility Signature of Funeral Service Licensee 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 UCK 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cereboursenlor occident Pnysician disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Examine attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Year Month Day in the past 12 months?
1 Yes No
9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown , orthal 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? yes 2 X No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25 Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2X No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Certificate: To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier lugust 33, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3130< 555 UCA 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 26

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** AUGUST 2009 MORTON PARIS 3:20 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MANOR CARE NURSING HOME BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 8. Date of Birth 07/08/1923 Birthplace (State or Foreign Country)

MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 216-14-4839 86 Vre Director Usual Residence of Decedent 10a. State 10c, City, Town or Location 10d. Inside City Limits Director MD BALTIMORE **BALTIMORE** 1 □Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6600 RIDGE ROAD 21237 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 MYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married \$ 1 ☐ Yes 2 X No Specify. Specify: WHITE 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BUILDING INSPECTOR BALTIMORE CITY HOUSING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HYMAN PARIS TILLIE ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3901 WHITE AVENUE, BALTIMORE, BRUCE PARIS / SON MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of MI KROPI) (ODE SHOP) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 Removal from State 4 □ Denation 5 □ Other (Specify) BALTIMORE, MD ISRAEL 08/25/2009 of Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN RD., PIKESVILLE, MD Enter the disease, or comp ications th caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one caus n each line Onset and Death Immediate Cause (Final EMENTIA disease or condition resulting in death) Sequentially list conditions and a list of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for all a consequence of Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Completed by

Physician /Medical Examiner

g physician and strans attending ph signed by t has certificate this thin 24 hours after death.

the Funeral Director: Apprehetely filled in by the fu

Be

Certification: To

Medical

State

Registrar

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Part II. Other significant conditions co	ontributing to death but not res	ulting in the underlying	ng cause given in Part I.	23e. Did tobacco u	se contribute to the cause of death?
				1 □ Yes 2 □	□ No 3 □ Probably 4 □ Inknown
				24a. Was an autopsy performed 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No
25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)	
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: A Nursing I	Home 5 ☐ Residence 6	☐ Other (Specify)
27. Man r of Death 1 Natural 5 Pending 2 Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury	y occurred
3 Suicide 6 Could not be	28e. Place of Injury - At he	ome, farm, street, fac	tory, office	28f. Location (Street and	d Number or Rural Route Number,

(Check one)	only	2□ N	lec
29b. Signati	re and	title of	CE
M	~		1

4 Homicide

20a Cortifio

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

ertifie

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

31. Date filed (Month, Day, Year)

AUG 26

and address of person who completed cause of death (Item 23a) (Type, Print)

Mon Woods Road. MD21234

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 23 M **Physician** August 2009 20 Baby Girl Robertson /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Johns Hopkins Bayview Medical Center Baltimore 8. Date of Birth Aug 3, 2009 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days Mary Iand 0^{Min} 1 □ M 2 🔯 F Director infant Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinating the rollified an once. 1 ☐ Yes 2¶ No Director Essex MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21221 USA 25 Malice Circle Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 21 No Specify: black Specify: Š 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) infant infant infant infant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk Be Patrisse Robertson ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Johns Hopkins Bayview Hospital 4940 Eastern Avenue Baltimore, MD 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 X Other (Specify) in state State Anatomy Board 655 W. Baltimore Street 21. Signature of Euneral Service Licensee Ronald S. Wade, Director Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Extreme **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of d any, leading to min edia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial-transit Exami Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2. No 4 Pregnant at time of death 5 Other (specify) P.0. the detached 9 I Inknown 9 Unknown þ cate has been signed page 2 should be dete Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' After this certificate 1. Yes 2 □ No 2**X**No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier LES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Battimore, MD, 21224 len 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 2009 August 9:33 A.M Gretel T. Simmons /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore County Middle River 2 Perch Court 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 1 1 F Months Days Hours Min. 14,1913 214-38-3124 95 burgh, PA. Director Usual Residence of Decedent 10d. Inside City Limits show 10a. State 10c. City, Town or Location ed other than "natural", or Items 23a or 28a-f sho event, the Medical Evaning must be notified at 1 ☐ Yes 2 ☐ No Baltimore County Middle River Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 21220 United States 2 Perch Court Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian. 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Specify: White Completed by 3 PWidowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Megones. Elementary/Secondary (0-12) College (1-4or 5+) 06 Education Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elise von Arx Robert Trog 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Edris S. Christello (Dau.) 2 Perch Court Middle River, Maryland 21,220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State August Evans Funeral Chapel Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2009 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Peaceful Alcernatives Funeral & Cremation Ctr., P.A. 21093 2325 York Road Timonium, Maryland 23a. Par 1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** A CUTE MYOCARDINE INFRICTION /Medical Due to (or as a consequence of): 6 YRS Examiner CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine burial-transi and Due to (or as a consequence of): Box 68760, attending physician certificate be Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ō Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 1∐Yes 2⊠No Ö 9 Unknown 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ģ HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed HYPERLIPIDEMIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed certificate 2 No 1 ☐ Yes 2 🖃 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this After thi funeral ofspital or Attending Pi iin 24 hours after death. 'e Funeral Direct's etelv.#" 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury Certification: 28d. Describe how injury occurred Division 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of 08/24/09 D0026575 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STE 200 COCKEYSVILLE, MD DAVID J. HARTIG, M.D. 10155 YORK RD

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 26

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav Year **Physician** Рм Iva Lorraine Schiller 2009 August 24, /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Brightview Assisted Living Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 08/09/1 921 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours Days 88 342-18-5421 Director Wisconsin Usual Residence of Decedent the Maryland 10a State 10b. County 10c, City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at Baltimore Baltimore 1 ☐ Yes 2X No Director MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with it Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 and highry or other traumatic event, the Medical Examiner must be no once. 8100 Rossville Blvd. 21236 U.S.A. by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: White 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home care 12 Nurse Aid 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Peral Lavey George Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4522 Ridge Road, Baltimore, MD 21236 Pamela Schmidt/Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date Evans Funeral 08/28/09 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Forest Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) Chapel- Bel Air Evans Funeral Chapel & Cremation Services 21. Signature of Funeral Service Licensee 8800 Harford Rd. Parkville, MD 21234 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on a ch line. Approximate Interval Between Onset and Death ate Cause (Final ise + e or condition resiting in death) **Physician** TCKR Wes /Medical Dueto (or a a consequence of): Examiner 2010 Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and stely filled in by the funeral director, page 2 should be detached for use as the buriat-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) this certificate has been signed by the al director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 24 hours a Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical npletely (Check only one) within 2 To the 29d, Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number

12

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. R. Rahnama, M. D. 9512 Harfor

M.R. Rahnama, M.D., 9512 Harford Rd. Suite 4, Parkville, MD 21234
31. Date filed (Month, Day, Year) | 32. Begistrar's Signature

AUG 2 6 2009

09-06124	
Dexter R. Street	

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State of Maryland / Department of He	ealth and Mental Hygiene

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		1- For State Registrar	Cei	rtificate of Death	Reg. No.	09 21000
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		4a. Facility Name (if not ins	titution, give street and number) d Hospital Center	4b. City, Town, or Location of	Death 4c. County of	
Fune	ral	5. Social Security Number	6. Sex 7. Age (In yrs. la	ast birthday) If Under 1 Year If Under	Prince Ge	
Direct		231-39-03 Usual Residence of Decede	79 1XM 2 F 22	Yrs. Months Days Hours		Foreign Country) VA.
yuk		10a. State 10b. Co	ounty 10c. City,	Town or Location		10d. Inside City Limits
Maryland 28a-f show any	once,	m_0 ST	: Charles Wo	aldorf		1 Yes 2 No
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death wit	must be r	11. Marital Status 1 Never Married 2	12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No	.S. 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F		7.
ırs after ural",	iii	3 Widowed 4	Divorced of Jess, Give Year or Dates: (Specify only highest grade completed)	1 Yes 2 No specify: 16a. Decedent's Usual Occupation (Give kir	Specify: Ind of work done 16b. Kind of Busi	3Lack
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than	traumatic event, the Medical	17. Father's Name (First, M	iddle, Last)		Name (First, Middle, Maiden Surname)	ntorov
Med Me	tic eve	19a. Informant's Name/Rela	tionship (Type, Print)	19b. Mailing Address (Street and Number	er or Rural Route Number, City or Town,	State, Zip Code)
, MD and 2 sho ealth and em 27 is	raums	Mar Garet (20a. Method of Disposition	C. Street/mother	3115 Knolkwatev Place of Disposition (Name of cemetery,	Date 20c Location - C	City or Town, State
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Baltim permit. Pag Department Important:	ury or	4 Donation 5 Oth 21 Signature of Funeral Se		22. Name and Address of Facility	420 H	
		Lisali.	Henry	B.K. HENRY FU	neral Home Wash.	,DC. 20002
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		Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence of	r).		
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici	completely filled in by the fun	3 Suicide 6 4 Homicide	Could not be determined (Specify) Major Road	me, farm, street, factory, office building, etc.	28f. Location (Street and Number or Town, State) N/B Route 301 at Missouri Ave	
e Hosp 124 ho e Fune	ely fi	29a Centiler	ng Physician: To the best of my knowledg	ge, death occurred at the time, date and place ad/or investigation, in my opinion, death occur		
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To th withir To th	complete	29b. Signature and title of ce	and manner stated.	DR L/ 29c. License number	29d. Date signed	(Month, Day, Year)
To th within To th	complete	29b. Signature and title of ce	and manner stated. ertifier FOR	O.C.M.E.	29d. Date signed August 6, 20	
To the within	complet	29b. Signature and title of ce	and manner stated. ertifier FOR errson who completed cause of death (Item.	O.C.M.E.	August 6, 20	

Physicia		Registrar			18765/6 Certificat	e ot l	Jeath			Reg. No.	2009	2134
i ilyaicia	an l	Decedent's Name (First, Middle,	, Last)						2. Date of De Month	ath Day	Year	3. Time of Death
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Funeral Director		217-28-7239	1 ∑ M 2□F		Months	Days	Hours	Min.	(Month, Da Feb 18	y, Year)	Coui	ntry)
TO		Usual Residence of Decedent							100 10	, 1).		
arylar show	١	MD Washing	rton	10c. City, Town							1	10d. Inside City Limits
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eath	eral	11. Marital Status	12. Was Decedent I	Ever in U.S.		2174 tent of H	-	igin? (Spe	cifv Yes or No		USA 14. Race - Americ	can Indian,
)36 Irs after d	by Funeral	1 ☐ Never Married 2 ☐ Marrie 3 🛣 Widowed 4 ☐ Divorced	Armed Forces?		13. Was Dece If Yes, spe 1 ☐ Yes		Specify:		Rican, etc.)		Black, White, Specify: whi	
2 hou attura	ted	15. Decedent	s Education	16a. D	Decedent's Usu	d Occup	ation		- 1	16b. Kir	nd of Business/In	dustry un
Baitimore, Maryland 21215-0036 sernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland bearment of Health and Mental Hygiene appartment of Health and Mental Hygiene mportant: If Item 27 is marked other than "natural", or items 23a or 28a-f show my injury or other traumatic event, the Medical Examiner must be notified at page.	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5	i+)	Give kind of wo life. DO NOT u brickla		during mos)	t of workin	ng			
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Baltimo		21. Signature Feneral Service L	. Wile, Dire	ector	State Baltime	nato	omy B	oard		Ba1	timore S	Street
THE STATE OF THE S		23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that caused only one cause on each lin	the death. Do no	ot enter the mod	e of dyin	g, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between
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/Medical Examiner		resulting in death)	Due to (or as	a consequence of):	U				.4	22	
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68 tiffical tiffical as th	edi			7,41								
Box 6	Physician/Medical	1F FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	pf pregnancy 2 Fetal death	3 ☐Ectopic p	eanancv				2	23d. Date of deliv	•
Ched for u	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at 9□Unknown		5 ☐ Other (sp						Month	Day Year
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Division or Vital Rec tor Attending Physician: The law after death. Director: After this certificate has b if in by the funeral director, page 2 sf	Certification:	2 ☐ Accident investigated investigated Accident investigated accident formula investigated inve	ot be 28e Place of inju	ury - At home, farn	M		Yes 2□		8f Location (Street and	d Number or Run	al Route Number,
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To the complete compl	Me	29b. Signature and title of certifier	. / \		290	. License	number			29d. Date	e signed (Month,	Day, Year)
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		30. Name and address of person w	who completed cause of de RCET, HAGE	eath (Item 23a) (T	ype, Print)					ч.	Ali	
	e	31. Date filed (Month, Day, Year)		ar's Signature		. ,	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10f Per ANA BD C895 9/10/09 III

1- For AMEND State of Maryland Department of Health and Mental Hygiene
1- Registrar State AMEND ITEM 19a per ab g895 9-1/-09 vt

Certificate of Death

Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month August 20, 2009 Physician 4:10 PM M Virginia M. Stella /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Queen Anne's Corsica Hills NUrsing & Rehab Centreville If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1□M 21 F 94 Director 398-09-9071 Mar 9, 1915 Wisconsin Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow or other traumatic event, the Mudical Examiner must be notified at 1 ☐ Yes 2€ No MD Howard Director Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5957 Cedar Fern Court USA or items 23a Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No à Specify: Specify: white 3 M Widowed 4 □ Divorced "natural", Completed 15. Decedent's Education 16a. Decedent's Usual Occupation unk 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be i and Mental h Raffaele Molinaro Teresa Morrone ည ^{19a} Informant's Name/Relationship (Type, Print) **Teresa**Theresa Newman/granddaughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 ie
any injury or other trau 5957 Cedar Fern Court Columbia, MD 21044 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee State Anatomy Board 655 W. Baltimore Street pector m Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Sause (Final disease or condition resulting in death) **Physician** diony opathe 1ears /Medical Examiner nears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of) Examiner Due to lef or Attending Physicien: The law requires that the deeth certificate be executed physicien and the burial-transit worderds is Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 4 Unknown Completed 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? res 2 No certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 25 No ၉ 1 ☐ Yes 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) After thi 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: A 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral C completely filled i To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who come leted cause of death (Item 23a) (Type, Print) ronley 610 Vatdemane 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

AUG 26

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 5R **Physician** AUGUST 21 2009 JOHN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NORTHWEST 10un HOSP ANDALLS RALTMORE MAL Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05-28-1929 6. Sex . Age (In yrs. last birthday) 5. Social Security Number **Funeral** 12 M 2□ F Months Days Hours Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examination injury or other traumatic event, If a Medical Examination injury or other traumatic event, If a Medical Examination injury or other traumatic event, If a Medical Examination injury or other traumatic event, If a Medical Examination in the injury or other traumatic event, If a Medical Examination is a second of the injury or other traumatic event, If a Medical Examination is a second of the injury of the injury of the injury or other traumatic event, If a Medical Examination is a second of the injury 10c. City, Town or Location 10d. Inside City Limits 10h County 1 ☐Yes 2 ☐No Woodlawn Director MD10f. Zip Code 10g. Citizen of What Country? 21207 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 14. Race - American Indian, 11 Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 □No Specify. If Yes, Give Year or Dates: Uhite Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ohn 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be emaker ပ္ 19b. Mailing Address (Street and Number or Rural Route Numb 19a. Informant's Name/Relationship (Type. Print) r, City or Town, State, Zip Code) Sunny Woodlam, ND 2120/ 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Crestour Cemetery 8-26-09 Marriotsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Vaushinc. Greene funeral Sis. 21. Signature of Funeral Service Licensee iborty Rd. Randalls tour mus 21133 aux 8728 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear dailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ATHEROS CLEROTIV CARDIOVASCULAR **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and the burial-trai Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria by Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) 1 □Yes 2 □ No the detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform certificate No. 2 🕒 1 □ Yes Physician; completely filled in by the funeral director. 25. Was case referr to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Medical Certification: To 1 Tyes 2 NER/Outpatient 3 □ DOA 1 Inpatient this 28a. Date of Injury (Month, Day, Year) 27. Man er of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident 24 hours after deati Funeral Director; 6 □ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2004

Registrar

State

DHMH 17 Rev 1/2001

(OUR)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5401

OUD

32. Registrar's Signature

ROTHKIN

31. Date filed (Month, Day, Year,

AUG 2 6 200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Yea Physician 4c. County of Death 20 14:00 HUS 08 DOROTHY SIEPHEN /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Randallstown If Under 24 Hrs. 8. Date of Birth (Month, Day, May 25, Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Year **Funeral** Days 1 ☐ M 2 🔃 Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 21s marked other than "natural"; or items 23a or 28a-f show any follow or other traumatic event, the Medical Examiner must he matter once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Funeral Director HIMOR 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 1 No 1 Yes Specify: Black Completed by 3 Widowed 4 □ Divorced 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Inknow UNKNOWN 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 620 Baltimer, buardian 10 N 20b. Place of Disposition (Name of cemetery, crematory of other p Date 20c Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 Removal from State 28/09 Woodlawn 21. Signal of Funeral Service Licensee hts MD 2120 1 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) COLONART ATHEROSLAGROSIS **Physician** /Medical Due to (or as a consequence of): **Examiner** RENOM TINURE CHMONIL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner HYPERTENSION Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death 1☐Yes 2☐ 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 donknown MYELOMA 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an MAS autopsy performed 2 110 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Inversing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 Homicide within 24 hours a To the Funeral C 1 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D00614 AUGUST, 20, 2005

5/2010

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed

ABEY Emisi



m.12

cause of death (Item 23a) (Type, Print)

OLD COUNT

RD RAMAMILSTOWN MD 21137

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Thomas Gilbert Scott 4:04 A^M 23, 2009 August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Ellicott City

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Nov. 1, 1938 Morningside Assisted Living Howard Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 🗆 F Nicarágua 052-32-7678 70 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show if than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2K No MD Ellicott City Howard 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 5330 Dorsey Hall Drive Apt 112 21042 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status within 72 hours after 1 ∐Yes 2 ZKNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Je filed wh. Elementary/Secondary (0-12) College (1-4or 5+) Engineer Dept of Defense permit. Pages 1 and 2 should be filed value of Health and Mental Hygis Important: If item 27 is marked other any Injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Spurgeon Scott Lola Cynthia Scott ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Benson Executor 13375 Piper Lane; Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Atlantic Crematory 8/27/09 Glen Burnie, MD 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facilin Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. +1630 Edmondson Avenue; Catonsville, MD 21228 21. Sign ture of Funeral Se Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death o not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** PANCREA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in the case. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Exami attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) the 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsy performe certificate 1 □ Yes 2 1 ☐ Yes 2 ☐ No After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the funeral or the funeral o 5 ☐ Pending investigation 1 □Yes 2 No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Records, P.O. Box 68760, Division of Vital

12V

State Registrar

Medical

29a. Certifier

(Check only one)

31. Date filed (Month, Day

29b. Signature and title of certifier

COLE

and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900 CATON AVE BALTIMORE MO 21229

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Bepartment of Health and Mental Hygiene 1 - State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 18 2009 4:20 a^M MARCEL JOSEPH August SHUBA 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Charlotte Hall Veterans Home Charlotte Hall St. Marys 9. Birthplace (State or Foreign Country)
Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 9 5. Social Security Number 7. Age (In yrs. last birthday) 1 M 2 □ F Days Hours 85 Feb. 216-18-3780 Yrs Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 XYes 2 No Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21225 435 Prince St. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑ Yes 2 □ No If Yes, Give Year or Dates: 1943–46 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 X Married 1 ☐ Yes 2 No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Keough High School Stationery Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Michael Szuba Marcella Rurka 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 435 Prince St. Balto. Md. 21225 Joane Shuba/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 8/24/09 Glen Haven Mem. Park Glen Burnie Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Hwy. Balto. Md. 21225 gramerouske 23a. Part 1. Enter the discusse or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure discribing one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PARDIAC ARRHYTHMIA disease or condition resulting in death) ONCESTIVE MEART Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Year Month 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? DEMENTIA 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an

Physician /Medical Examiner

attending physician and for use as the burial-transit

signed by the a

After this certificate has been si funeral director, page 2 should t

The law requires that the death certificate be executed

Box 68760,

P.0.

Division of Vital Records,

Hospital or Attending Physician:

To the

death.

within 24 hours after death

To the Funeral Director:
completely filled in by the

Examine

Physician/Medical

Completed by

Be

Certification: To

Physician

/Medical

Examiner

10a. State

Md.

Funeral

Director

ral", or items 23a or 28a-f show

"natural"

than

item 27 is marked other traumatic ev

Department of Health al Important: If item 27 is any Injury or other trau

The Medical

Pages 1 and 2 should be filed within 72 hours after

and Mental Hygiene.

Saltimore, Maryland 21215-0036

Director

Funeral

2

Completed

Be

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

V	A	S	C	U	LA	12

autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No

1 ☐ Yes 2 No 26. Place of Death (Check only one)

25. Was case referred to medical examiner? 1 Yes 2 No

Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

27. Manner of Death 28a. Date of Injury (Month, Day, Year) 5 ☐ Pending investigation 1 Natural 2 Accident 3 Suicide 6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only

4 Homicide

tlacertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

29c. License number

29b. Signature and title of certifie

MD D67788 29d. Date signed (Month, Day, Year) 8.18.2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAO EENA 31. Date filed (Month, Day, Year) KODA

14090 HG Trueman Rd. Suite 2300 Solomons,

State Registrar

DHMH 17 Rev 1/2001

		for State Registrar	State of M	•	partment of l <i>ertificate of</i>			jiene _{eg. No.} 200	9 27345
Physici /Medi		Decedent's Name (First, Midd JUDY	dle, Last)	S	PANGENTHA	L.	2. Date of Dear Month AUGUST		3. Time of Death 12:30 A M
Examir		4a. Facility Name (If not institution EMERITUS OF	, ,			or Location of Deat	h	4c. County of E	
Funeral Director	Γ	5. Social Security Number 216-48-3109	6. Sex 7. Ag	ge <i>(In yrs. last birthd</i> 55 Yrs	Months Days	If Under 24 Hrs Hours Min.		953	Birthplace (State or Foreign Country)
yland how		Usual Residence of Decedent 10a. State 10b. Count	у	10c. City, Town or	Location				10d. Inside City Limits
the Mai 28a-fs	Director	MD BAL 10e. Street and Number	LTIMORE	BALT	IMORE 10f. Zip Code		1	0g. Citizen of Wha	1 □ Yes 2 X No t Country?
eath with sa 23a or	Funeral D	6814 CHEROKEE	DRIVE	Ever in II S 1	2120		Specify Ves or No-	USA	American Indian,
urs after d	þ	11. Marital Status 1 □ Never Married 2 □ Ma 3 □ Widowed 4 ☑ Divorce	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give	No No	3. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 No		to Rican, etc.)		WHITE
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examine I mist be notified at once.	Completed	15. Decede (Specify only high Elementary/Secondary (0-12)	ent's Education est grade completed) College (1-4or 5	(G (if	ecedent's Usual Occu ive kind of work done e. DO NOT use retire	during most of wo	rking	16b. Kind of Busine	ess/Industry
y wan y allo Zin In Zin Zin Zin Zin Zin Zin Zin Zin Zin Zi	Be Cor	17. Father's Name (First, Middle	·		AB TECHNIC	18. Mother's Na	me (First, Middle, i	MEDICAL Maiden Surname)	
should b ind Ment marked umatic e	Tol	LOUIS 19a. Informant's Name/Relation		PANGENTHAL 19b. M	ailing Address (Stree	BESS I		SENI r, City or Town, Sta	
T and 2 Health a em 27 is		JULIAN SPANGEN	NTHAL / BROTH	1	BENFORES	T DR. EAS		NA PARK,	
Pages treent of I tant: If ite		1		cemetery, c	HAVAS CHES	SED 08/2	4/2009	RANDALLS	TOWN, MD
Departing Departing Departing any in sonce.		21. Signature of Funeral Service	e Licensee		22. Name and Address 8900 REIS				
Physician // // // // // // // // // // // // //		23a. Part 1. Enter the disease, of shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	a. BREAS	d the death. Do not ne. T CANCER a consequence of):	enter the mode of dy	ing, such as cardia	c or respiratory arr	rest,	Approximate Interval Between Onset and Death 6 YEARS
Examiner	er	Sequentially list conditions, if any, leading to immediate the standard cause (Disease or injury	b	a consequence of):					
ficate be executed physician and sthe burial-transit	al Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	a consequence of):					
The law requires that the death certificate the has been signed by the attending phyage 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal death	3 ☐ Ectopic pregnan 5 ☐ Other (specify) _	су		23d. Date o Month	
w requires that been signed b should be deta	þ	Part II. Other significant condit	ions contributing to death b	out not resulting in the	e underlying cause gi	ven in Part I.		bacco use contribu es 2 ☐ No 3 [te to the cause of death? Probably Unknown
ician: The law re certificate has be ector, page 2 sho	Completed							sy prio med? dea a ZaNo 1 □	e autopsy findings available r to completion of cause of th? Yes 2 □ No
hysicians this certifical	To Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatie	ent 2 ☐ ER/Outpa	tient 3 L DOA	her: 4 Nursing I	ath (Check only on Home 5 ☐ Resid	<i>ence</i> 6 ☐ Other (Specify)
Attending Physician: r death. ector: After this certifici	ation:	E Divisionit	tigation		y Wo	iry at rk?]Yes 2 □ No	28d. Describe h	ow injury occurred	
To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director	Certification:	3 Suicide 6 Could 4 Homicide deteri	minad 20e. Place of Int	ury - At home, farm, c. (Specify)	street, factory, office		28f. Location (S. City or Town	treet and Number on, State)	or Rural Route Number,
n 24 hou n 24 hou ne Funer pletely fill	Medical		ing Physician: To the best Il Examiner: On the basis of and manner st	of examination and/o					
To the within com	Ž	29b. Signature and title of certific	Air horn	Dsa 140	29c. Licen	se number 2739	4 2	29d. Date signed (M	Agnth, Day, Year)
		30. Name and address of person JAMES P. R1	n who completed cause of c		pe, Print)		IMODE NO	040	
Sta Registr		31. Date filed (Month, Day, Year		rar's Signature	SATON AVEN	ue, BAL[]	HYUKE, MD	2122 9	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2009 8145 PM M linker eresa 25 4a. Facility Name (If not institution, give street and number) Nursing 4c. County of Death 4b. City, Town, or Location of Death St. Elizabeth Rehabilitation & **Baltimore** Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 🕶 F Days Hours Min. 216-01-9875 90 Maryland 3011 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location **Baltimore** 1 XYes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2515 Boston Street #1002 21224 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2X No Specify: White 3 ☐ Widowed 4 X Divorced

16a. Decedent's Usual Occupation

Homemaker

(Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

AT Home

18. Mother's Name (First, Middle, Maiden Surname)

Teresa Fischer

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2515 Boston Street #1002, Baltimore, MD 21224

Physicia /Medic

Physician

/Medical

Examiner

10a. State

Director

by Funeral

Completed

Be

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MD

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

John A. Brown

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type. Print)

Maris St. Cyr/ Daughter

12

College (1-4or 5+)

Funeral

Director

ir than "natural", or items 23a or 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ir. M. of or I. Earl is a suit injury or other traumatic event, Ir. M. of or I. Earl is a suit in a standard or any injury or other traumatic event, Ir. M. of or I. Earl is a suit in a standard or any injury or other traumatic event, Ir. M. of or I. Earl is a standard or any o

Baltimore, Maryland 21215-0036

Examin

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Division of Vital Records, P.O. Box 68760,

		20a. Method of Disposition		20b. Place of Disposition (/	Name of or other place)	Date		_ocation - City or	Town, State
		1 ☐ Burial 2 🔀 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Evans Funeral C	haper	08/26/	^{'09} Fo	rest Hill,	MD
once.		21. Signature of Funeral Service Licen	see Walk	/ Evans	and Address of Far Funeral Cha arford Rd.	pel & (Parkvil	Cremation Ide, MD	n Services 21234	3
n al er	al Examiner	3a. Part 1. Enter the disease, or comphock, or he at failure. List only impediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or knjury that initiated events resulting in death) Last	Due to (or as a Due to (or as a C.						Approximate Interval Between Onset and Death
	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions of	23c. If yes, outcome of 1	P☐ Fetal death 3☐ Ectop time of death 5☐ Other	., ,,	art I.			ilivery Day Year of the cause of death? robably 4 ① Unknown
	Completed	GERD OSteo poro	515				24a. Was an autopsy performed?	24b. Were a prior to death?	utopsy findings available completion of cause of
	Be	25. Was case referred to medical			26. Pia	ace of Death (C			
		examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatien	nt 2 ER/Outpatient 3 D	DOA Other: 4 12	Nursing Home	5 Residence	6 ☐ Other (Spe	ecify)
	Certification: To	27. Manner of Death 1 Natural 5 Pending investigation		Year) Injury M	28c. Injury at Work? 1 □ Yes 2	28d	Describe how inj		
	Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur- building, etc.	y - At home, farm, street, fac (Specify)	tory, office	28f.	Location (Street a City or Town, Sta	and Number or R te)	ural Route Number,
	Medical	29a. Certifier (Check only one) 1 ☑ Certifying Ph 2 ☐ Medical Exam	nysician: To the best of niner: On the basis of and manner state	f my knowledge, death occur examination and/or investiga ed.	red at the time, date tion, in my opinion,	e and place, and death occurred	I due to the cause at the time, date a	(s) and manner a nd place, and du	s stated. e to the cause(s)
	Ĭ	9 -	CRIP		29c. License number	15	5	late signed (Mon 312510	9
		30. Name and address of person who	completed cause of dea	19h 3320	Benson	Ave.	Baltin	acre M	0 21227
Stat	_	31. Date filed (Month, Day, Year)	32. Registrar	r's Signature					

DHMH 17 Rev 1/2001

State Registrar

AUG 26 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 721 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 7:00 A^M HOWARD 08 14 009 THOMA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner <u>Baltimore Washington Med Ctr</u> Burnie Anne Arundel Glen 8. Date of Birth (Month, Day, Year) 05/29/1934 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** 1 **2** M 2 □ F Months Davs Hours Min. 212-30-9790 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 ☐ Yes 2 ☐ No Anne Arundel Pasadena 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21122 U.S.A. 260 Carroll 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 2 2 No 1954 -14. Bace - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. Be Completed by If Yes. Give Specify: White 3 Widowed 4 Divorced Year or Dates: 1956 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Bethlehem Elementary/Secondary (0-12) College (1-4or 5+) Electrician Steel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ George Howard Thomas Lillian Pearl Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Hicks / Daughter Glen Road, Pasadena, MD 21122 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 🖫 Cremation 3 ☐ Removal from State Bayview Crematory 108/18/09 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune al Service Licensee 22. Name and Address of Facility G.J.Gonce Funeral Home, 169 Riviera Drive, Pasadena, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** HROMSOEMSOLIC VASCULAR DISEASE disease or condition resulting in death) MOUR /Medical Due to (or as a consequence of): Examiner ATHEROSC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) HYPERTENSION Due to (or as a consequence of): 14PER CHOLESTERO Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No 24a. Was an autopsy performed? 1 □ Yes 2 ■No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and P.O. Box 68760, Division of Vital Records, completely filled in by the funeral director, page 2 should

within 24 hours a

Registrar

erzon

6 Could not be determined

3 Suicide

29a Certifier

4 🗌 Homicide

(Check only one)

29b. Signature and title of certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1251325

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1 ☐Yes 2 ☐No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8028 RITCHIE HWY STE 301 21122

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 2009 /Medical 4c. County of Death, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Regiona 172 If Under 24 Hrs. If Under 1 Year Birthpla Social Security Number 7. Age (In vrs. last birthday) Date of Birth (Month, Day, **Funeral** Hours Months Days Min. 70 Yrs. December 28, 1938 North Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural". 10a. State 10b. County 10c. City. Town or Location 10d, Inside City Limits (Yes 2 □ No Funeral Director MD 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 20708 USA ane 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 20 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Specify. Completed by Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) are 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Deurlal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Puneral Service 22. Name and Address of 10226 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physiclan: The law requires that the death certificate be executed te attending physician and Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 2 No 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Inpatient After this 28a. Date of Injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural
2 □ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division of Vital Records.

Medical Certification: To within 24 hours after death.

To the Funeral Director: A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as success.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's gnature 31. Date filed (Month, Day, Year) State AUG 26 Registrar **ORIGINAL**

09-06584 Rattl

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dical Examir		Rattha					b. City. To		antion of I		August 22	, 2009	ounty of Deat	1427	nrs
		4a. Facility Name (if n University Hos		live street and nu	imber)		Baltim		ocation of t	Deam		40.0	ounty of Deat		
Funeral		5. Social Security Nun		Sex	7. Age (In yrs.	last birthday)	If Under		If Under 2 Hours			•	(AYYYY) 9. Bi Forei	an	
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any	-	Usual Residence of D 10a. State 10	ecedent b. County		10c. City	, Town or Locati	on							10d. Insid	e City Limits
*			Anne A	rundel		len Bur								1Ye	s 2 X No
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more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f she orther transmatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married	2 Marri	A a .! =	cedent Ever in U		s Deceden es, specify				cify Yes or No ican, etc.)	- 14	Race - Ame White, etc.	rican Indian,	Black,
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72 hou n "na	Completed	Elementary/Second	dary (0-12)		1-4 or 5+)		ost of work	•	OO NOT us	se retired	d)	L			
5-0036 iled within 7. Hygiene. I other than the Medical	Į į			4		Electr	iciar						trical		
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours afte Department of Health and Mental Hygiere. Important: If item 27 is marked other than "natural", injury or other tranmatic event, the Medical Examiner.	Be Co	17. Father's Name (Fi		st)					amy		First, Middle, I	Maiden Su	ırname)		
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/Medical		failure. List only Immediate Cause (Fir		each line. a. Hanging											n Onset and Death
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Sox 6876 death certificate e attending phy for use as the	sician/M	past 12 months?	9 Unkno	4 Preg	nant at time of o	looth -	her (Spec	ify)							
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Vita hysici this co		examiner? 1 ✓ Yes 2	No	Hospital: 1		✓ ER/Outpatient					Home 5	Residen		ier.	
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11	ĺ	30. Name and addres Theodore M.			use of death (Ite ant Medical		111 Pe	nn Stre	eet. Balt	imore	, MD 2120	1			
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) nom 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) N BALTO. MD Romwel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 5. Social Security Number Days Hours 219-20-175 Usual Residence of Decedent MD 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Yes 2□No MD N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 815 E. 41st Street 21218 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 7 Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Crab Picker Supervisor Bay Island 3rd N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Jolley Rosie Etta Ward 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Thompson 815 E. 41st Street Baltimore, MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Maurial 2 ☐ Cremation 3 Removal from State 8/24/2009 Baltimore MD Trinity Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MARCH FUNERAL HOME-EAST 1101 E. North Avenue Baltimore, 21202) or MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Demontiv Due to (or as a consequence of) dry cusc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of, Diapolas Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown

Physician /Medical **Examiner**

sician and burial-tran

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Funeral Director

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Completed

Be

2

permit. Pages 1 and 2 should be filed within 72 hours after death with the Man Department of Health and Mental Hygiene.

Department of Health and Mental Hygiene.

Induportant: If item 27 is marked other than "natural", or Items 23a or 28a-f sh any Injury or other traumatic event, the Medical Examiner must be notified a once.

Baltimore, Maryland 21215-0036

Examine Physician/Medical Be Completed by Certification: To

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and

Division or Vital Records, P.O. Box 68760,

Som Trong

Part II. Other significant conditions	contributing to death but not res	sulting in the underlying	cause given in Part I.	1 Yes 2 No 3 Probably 4 Junknow
				24a. Was an autopsy performed? 1
25. Was case referred to medical			26. Place of Dea	ath (Check only one)
examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐]ER/Outpatient 3 ☐ □	OCA Other: 4 Nursing F	Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Man of Death atural 5 ☐ Pending 2 ☐ Accident investigatio		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be determined		ome, farm, street, factory)	ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
				e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)

29c, License number

D5274

State Registrar

in by the

Medical

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) 08-16-09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MIRNARA

25 US mount 21204 GM

31. Date filed (Month, Day, Year) 32. Registrar's Signature 26

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Winston Terry 10:58 PM 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore 4c. County of Death Examiner Union Memorial Hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours M 2□ F Director 218-36-1021 16 39 08 70 VA Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Nedical Examiner must be notified.

■ traumatic event, the Nedical Examiner must be notified.

■ traumatic event, the Nedical Examiner must be notified. Director 1 X Yes 2 □ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 214 East 23rd Street 21218 U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: 2 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Various Jobs 9th grade Laborer Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked of Albert Terry Winnie Tucker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health a
Important: If Item 27 is
any Injury or other trae 5611 Higate Drive, Baltimore, Md 21215 Thomas Terry-Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/28/09 Mt. Zion Baltimore, Md nature of Funeral Service Licensee 22. Name and Address of Eacility that the Eacility that t Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disse or condition sulting in death) **Physician** 21 0AYS HEPATO RENAL SYNDROME /Medical Due to (or as a consequence of): **Examiner** ABUSE ALCOHOL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and burial-transit Due to (or as a consequence of) Box 68760, the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Ö 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u></u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐ Yes 2 ☐ No Division of Vital 1 □ Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical ExamIner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) restort physician AT2438946 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 EAST UNIVERSITY PARKWAY BAUTIMORE, MD 21218 SIRA DUSON 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month AUGUST Year 2009 06:28A Vollkommer Edward Raymond 4c. County of Death 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death Baltimore Center Towson Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Oct 17 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number Days Hours Months 1 2 F 85 N.Y103-14-6372 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 □Yes 2 No Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number United States 21239 7012 Sherwood Road 12. Was Decedent Ever in U.S. Armed Forces? 1≜Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No White 3 Widowed 4 Divorced Year or Dates: WWI 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Heating And Oil Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Vollkommer Katherine Brown Jacob 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7012 Sherwood Road Baltimore, MD 21239 Dolores Ambrose /Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition Aug 24 1 ☐ Burial 2 ☐ Peremation 3 ☐ Removal from State Beltsville, Maryland 2009 Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee M01443 Cremation and Funeral Alternatives Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) HYPOXEMIA Due to (or as a consequence of): CHRONIC OBSTRUCTIVE PULMONARY DISEASE countielly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): ves, outcome of pregnancy 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 ☐ Yes 2 No 1 □ Yes 2 Dillo 26. Place of Death (Check only one) 25. Was case referred to medical examiner? 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Year) Natural 5 Pending investigation 2 Accident

/Medical Examiner and burial-tran Box 68760, attending physician for use as the buria certificate be as for signed by the a <u>P</u> Division of Vital Records, has

spital or Attending Phystcian: Theoris after death.
Ineral Director: After this certificate y filled in by the funeral director, pa

To the Hospital of within 24 hours at To the Funeral D

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

"natural", or items 23a or 28a-f show

event, the Medical

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permit. Pages 1 and 2 should be filed I Department of Health and Mental Hygi Important: If item 27 Is marked other any injury or other traumatic event, II

Physician

within 72 hours after death with

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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Physician/Medical 9 Completed Be ဂ္

Medical

Examine Certification: 3 Suicide

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 Unknown

	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury		28c. Inji
ation			M	1[
ot be ned	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stree	t, facto	ory, office

M. D.

1 ☐Yes 2 ☐No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

TOWSON, MARYLAND 21204

29a. Certifier (Check only

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier 30. Name and address of person who complete,

M

OSLER DRIVE

DØØ63974

29d. Date signed (Month, Day, Year)

State Registrar

SIDDIQI IRAM E. 31. Date filed (Month, Day, Year)

6 ☐ Could no

32. Registrar's Signature

ause of death (Item 23a) (Type, Print)

7601

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** AUĞÜST 08:39A M VonPostel Jr. 2009 Richard Lyman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Towson Baltimore Saint Joseph Medical Center 8. Date of Birth (Month, Day, Year) 11/01/1948 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours Min. 1**⊠** M 2□ F 214-50-1063 60 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examined: ust be retiffed at Baltimore Parkville 1 Yes 2 No Director MD 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21234 USA 4 Shawnee Court, Apt. 303 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ™ S 2 □ No If Yes, Give Year or Dates: US Navy Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 XNo Specify: Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Refrigerator Mechanic Housing 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Ryan Richard Lyman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type. Print) 4 Shawnee Court, Apt. 303, Parkville, MD 21234 Dennis Roberts / Brother Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 8/25/2009 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) Ardent crematory 22. Name and Address of Facility Maryland Cremation Services 21. Signature of Funeral Service Licensee Dorota , Marshall W Marsha M PO Box 1413, Baltimore, MD 21203 e 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** CORONARY ARTERY DISEASE /Medical Due to (or as a consequence of) Examiner ACUTE MYOCARDIAL INFARCTION if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit CARDIOGENIC SHOCK Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. the detached 9 | Unknown 9 Unknown signed by t I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No spital or Attendi fours after death. heral Director: A 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar eru

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PREWITT,

31. Date filed (Month, Day, Year)

30. Name and address of person ho completed cause of death (Item 23a) (Type, Print)

7601

32. Registrar's Signature

reun

OSLER

29c. License number

D57329

TOWSON, MARYLAND

DRIVE

arks

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Physician 2009 Margaret W. Walter /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Union Memorial Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Year) **Funeral** Months Days Hours Min 1 □ M 2 🖫 F 78 1931 Maryland 213-30-9222 June 20, Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ntt: If tem 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wedfort Examinating the notified at once. 10a. State 1 □Yes 2 No Chase Director Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21220 5 Bayou Court Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 TNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: δ 3√2 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Childcare Caregiver 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Knapp Wilbur Wachter ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5636 Gunpowder Road-White Marsh, Maryland 21162 Glenn Bittorf-20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Evans Funeral Chapel Aug.28, 2009 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland and Cremation Svr. Belair 8800 Harford Road Parkville,Maryland 21234 22. Name and Address of Facilit 21. Signature of Furieral Service Licensee Evans Funeral Chapel and Cremation Services sleman 23a. Par 1. ... let rue/isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he or lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ardio pul mon an 10 mins **Physician** /Medical Due to (or as a coor equince of): Examiner Sequentially list our different if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9 Unknown is certificate has been signed by director, page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 🗌 Yes 2No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) funeral . Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RESIDENT who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Mezrich HARROR VIEW DR, BALTIMORE, Jonathan 31. Date filed (Month, Day, Year) 32 Registrar's Signature State AUG Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	aryland / Der <i>C</i> e	ertificate of		-	Reg. No.	09 27350
	Physici	an	1. Decedent's Name (First, Middle, L					Date of Dea Month	Day Yo	3. Time of Death
	/Medic			THARINE E					23, 200	
	Examin	er	4a. Facility Name (If not institution, g				or Location of Death	١	4c. County of	chester
****			Mallard Bay Nur 5. Social Security Number 6.		e (In yrs. last birthda			8. Date of Birt		Birthplace (State or Foreign Country)
L	Funeral Director		218 - 22 - 9937 Usual Residence of Decedent	1□M 2 F F	80 Yrs.	Months Days	Hours Min.	10/23/	1928	Maryland
	yland now		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	a-f st	Funeral Director	MD Dorch	ester	C	ambridge	<u>)</u>			1 □Yes 2 ▼No
	or 28	Dire	10e. Street and Number		•	10f. Zip Code			10g. Citizen of Wha	
	23a	ral	5936 Horns Po	7			21613			.S.A.
	er der items	nue	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	B. Was Decedent of If Yes, specify Cub	Hispanic Origin? (S oan, Mexican, Puert	pecify Yes or No- o Rican, etc.)	- 14. Race - Black, I	American Indian, White, etc.
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at	Completed by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes 2 ☑ If Yes, Give Year or Dates:	140	1 □Yes 2 ■No	Specify:		Specify:	White
15-	"natu	ete	15. Decedent's (Specify only highest of	Education irade completed)	16a. De	cedent's Usual Occu ve kind of work done b. DO NOT use retire	pation during most of wor	king	16b. Kind of Busin	ness/Industry
12	within iene. than "	Ĕ	Elementary/Secondary (0-12)	College (1-4or 8	5+) IIII	Homemak			Own	n Home
	filed Hygi other ent,	Be	17. Father's Name (First, Middle, La	st)		Пошешак		ne (First, Middle,	Maiden Surname)	i Home
Maryland	ould be I Mental arked o atic eve	70 B	Charles Alexa	ınder McCı	urdv		Marie	Franci	s Gleaso	on
ary	should and Mer is marke	-	19a. Informant's Name/Relationship			iling Address (Stree				
	1 and 2 Health a em 27 i		Donald S. Wagne	r / Husb				ad, Cam	bridge,	MD 21613
ore	of Hi fiten		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3	□ Removal from State	20b. Place of Dis	position (Name of rematory or other pla	ace)	Date	20c. Location - Ci	ty or Town, State
Ë	Pa int		4 ☐ Donation 5 ☐ Other (Spe	cify)	New Cat	<u>hedral C</u>	<u>em 08/2</u>	26/09	<u>Baltim</u>	ore, MD
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr once.		21. Signature of Funeral Service Lic	ensee /						al Home, PA
	40200	- 3	23a. Part 1. Enter the disease, or co	malications that saves						MD 21122
			shock, or heart failure. List on Immediate Cause (Final	ly one cause on each li	ne.					Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Cerel	oral Va	scular	accide	nt-nen	norrhagi	c Iweek
4	Examiner		4	hup	ertensi	00				Duexs
	7 =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due la (4r as	a consequence of):					7,59,50
R	rtificate be executed ng physician and as the burial-transit	Examiner	that initiated events	C						
30,	be execian a	Ĕ	resulting in death) Last	Due to (or as	a consequence of):					
98760چ	cate t	edical	•	d						
9 x	Physician: The law requires that the death certificate be executed ribis certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy				23d. Date	of delivery
Box	leath cert attendin	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death	3 ☐ Ectopic pregnan 5 ☐ Other (specify)			Month	The second secon
P.O.	law requires that the das seen signed by the 2 should be detached	Physician/M	1 □Yes 2 ເ⊠No 9 □ Unknown	9 🗆 Unknown						
Э,	s that gned to e deta	۶.	Part II. Other significant conditions		out not resulting in the	underlying cause gi	iven in Part I.	23e. Did t	obacco use contrib	ute to the cause of death?
Records,	en sig	Completed by	hyperi pide	mis				1 🗆 '	Yes 2 No 3	☐ Probably 4 ☐ Unknown
ecc	law re as se 2 sho	plet				,		24a. Was	osv I prio	ere autopsy findings available or to completion of cause of
<u> </u>	The ate h	S						perfo 1 □ Yes	rmed? dea	ath? ∐Yes 2 □ No
of Vital	ician: The law certificate has ector, page 2 s	Be	25. Was case referred to medical examiner?					ath (Check only o	nne)	
of	Physical this call direct	၉	1 Yes 2 No		ent 2 ER/Outpat	ient 3 🗆 DOA			dence 6 □Other	
L C	ding Phys 7. After this funeral di	ioi	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of Inju (Month, Da	ury 28b. Time ay, Year) Injur	y Wo	ury at ork? ⊒Yes 2 □ No	280. Describe	how injury occurred	
Division	I or Attendi after death, Director: A I in by the fu	fical	3 ☐ Suicide 6 ☐ Could not	.	jury - At home, farm, tc. <i>(Specify)</i>			28f. Location (Street and Number	or Rural Route Number,
Ο	afor A after Dire	Certification:	4 ☐ Homicide determine	building, el	tc."(Specify)	,,		City or To		
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best aminer: On the basis of and manner st	of examination and/or	eath occurred at the investigation, in my	time, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and mand date and place, an	ner as stated. d due to the cause(s)
	To the within To the Comple	Me	29b. Signature and title of certifier			29c. Licen	nse number		29d. Date signed (
	> - 0	1	> 5xpans	on or		He	05997	3	8/24	109
		i	30. Name an landress of person wh	o completed cause of		e, Print)	05997 Cambr		41.0	
_	10		Patricia Joi	inson 10		n ble	Cambr	idge	MD	
	Sta		31. Date filed (Month, Day, Year)		rar's Signature					
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ORIGINAL

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 00:52 AM **Physician** AUGUS 2009 WILSON 20 DENISE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BAYVIEW MEDICAL CENTER BALTIMORE BALTIMORE JOHNS HOPKINS 9. Birthplace (State or Foreign Maryland If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 5. Social Security Number Funeral Hours Min Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, It. Medical Evant is a must be notified at once. 1 Yes 2 □ No Director timpre 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 <u>a</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SON 19b. Mailing Address (Street and Number or Rural Route Number, 19a. Informant's Name/Relationship (Type. Print) Fatier 20a. Method of Disposition Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/26/2009 Memorial Par 22. Name and Address of Facility
Joseph L. Russ Fu
2222 W. North Ave. 23a. Par/1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician NEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?

1 Yes 2 No
9 Unknown 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Deat 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Junush 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 NORTH WOLFE STREET BALTIMORE MARYCAND IUROWSK 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $\overset{\text{Day}}{2}$ 3, Physician August 2009 6:15pм Anthony Stanley Witkowski, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Richey Hospice Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7 / 24 / 1 9 4 1 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Months Days 1**∑** M 2□ F 68 MD 213-42-4996 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Wedfeal Evantiant interpretation any injury or other traumatic event, the Wedfeal Evantiant interpretation and once. 1 Yes 2 No Director Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA 21201 838 Nort Eutaw Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2X No Specify: White ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher, Massage Therapist Health 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Katherine Borkowski S. Witkowski, Sr. Anthony 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kathleen Witkowski-Stanley/ Daughter 39 Brook Meadow Circle, Shrewsbury, PA 17361 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/25/2009 Hanover, MD Ardent Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD 21203 21. Signature of Funeral Service License Dorota Marshall oute W Markenll Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final MYELODYSPLASTIC SYNDROME

Due to for as a consequence of): 3 YRS **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in list and avents. Due to (or as a consequence of) Examine law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Ye ar in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 Duknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ NON-HODSKINS LYMPHOMA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 □No HEADT FAILURE 1 ☐ Yes 1 □Yes Was case refe examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending Natural 2 Accident 5 Pending 1 ☐Yes 2 ☐ No investigation within 24 hours after deati To the Funeral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

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Division

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State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

ORIGINAL

32. Registrar's Signature

MAFILE COLUMBIA, MD 21045

30. Name and address person who completed cause of death (Item 23a) (Type, Print)

09-06571

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

anice Yarborough	State of Maryland / Department of 1-For State Certificate of Registrar		ygiene Reg. No. 2 <u></u>	00 070
Physician/	Decedent's Name (First, Middle,Last)	10.11	2. Date of Death Month Day Year August 22, 2009	3. Time of Death 0842 hrs
Medical Examiner	VANICE VARBOROL 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		h
	3405 Dupont Avenue	Baltimore	s. 8. Date of Birth(MM/DD/YYYY) 9. Bi	ithalaaa /Stata ar
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Months Days Hours Mir	Fore	ign ountry) Mary land
Director	158-44-1682 1 M 2 X F 57 YI	S.	06/80/1930	
any	10a. State 10b. County 10c. City, Town or Local			10d. Inside City Limits 1 Yes 2 No
Maryland 28a-f show any <u>d at once.</u> ector		10f. Zip Code	10g. Citizen of What Co	
ith the Maryland 23a or 28a-f sho notified at once. al Director	10e. Street and Number	2/2/5	13.5.A.	,
5 72 hours after death with the Maryland n "natural", or items 23a or 28a-f she a Examiner must be notified at once leted by Funeral Director		as Decedent of Hispanic Origin? (S	Specify Yes or No- 14. Race - Ame	erican Indian, Black,
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21215-0036 Juld be filed within 7 Mental Hygiene. marked other that ic event, the Medical To Be Comple	17. Father's Name (First, Middle, Last) CHARLIE YARBOROUGH	1		5010
212 ould be d Ments s mark lic ever			Rural Route Number, City or Town, Sta	
nore, MD 21215-0036 siges I and 2 should be filed within 72 hours after nt of Health and Mental Hygiene. It: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner To Be Completed by	NAKIA HILL LDAUGHTER) 322	9 NORMOUNT	AVE., BALTIMORE Date 20c. Location - City	mD 21216 or Town, State
Ore, ses I ar of Hez If ite	1 V Burial 2 Cremation 3 Removal from State crematory or	other place)		
ta me D	24 Cinneture of Europe Contine Licenses	Name and Address of Facility	128/2009 BALTIMON	RE, MARYLAND
Balti permit. Departu Import injury	16 Dietich N. h Jellams 13	IMO N. FULTON A	JR. FUNERAL HUME VE., BALTIMORE, MI	21217
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not ente failure. List only one cause on each line.		or respiratory arrest, shock, or heart	Approximate Interval Between Onset and Death
/Medical taminer	Immediate Cause (Final disease or condition resulting in death) a. Methadone intoxica Due to (or as a consequence of):	tion		200
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ted nsit	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
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D. Box 6876C t the death certificate by the attending phys ached for use as the bighty	1 Yes 2 No 9 V Unknown g Unknown			the second death?
	Part II. Other significant conditions contributing to death but not resulting in the End-stage renal disease	e underlying cause given in Part I.	23e. Did tobacco use contribute 1 Yes 2 ✓ No 3 F	
Division of Vital Records, P.O. tall or Attending Physician: The law requires that the rate death. The law requires that the this certificate has been signed by led in by the funeral director, page 2 should be detach the contribution. To Be Completed by Definition of the page 1.	Eliq-stage Tenar disease			autopsy findings available
Records, The law requires ficate has been sig page 2 should be		<u> </u>	_ autopsy prior performed? death 1 Yes 2 ✓ No 1	to completion of cause of 1? Yes 2 No
tal Rections: The certificate ector, page		26.Place of Death (Che		
F Vital Physician r this certi	1 ✓ Yes 2 No		sing Home 5 Residence 6 VO	ther: Scene
ding Pl		1 Yes 2 X No	28d. Describe how injury occurred unk	
ivisior I or Attend after death Director:	2 Accident Pending Investigation Rd 8/22/09 Fd 8: 28e. Place of Injury - At home, farm, s	30 am	28f. Location (Street and Number of or Town, State) 3405 Du	Rural Route Number, City
Division o spital or Attending hours after death. neral Direction: After filled in by the fune	3 Suicide 6 X Could not be determined (Specify) house		Baltimore, MD	
Division of Vital Rectoring Division by Section 1961 Within 24 hours after death. The Prothe Funeral Director: After this certificate I completely filled in by the funeral director, page Condition Certification: To Be Company of the Condition of Certification: To Be Company of the Condition of Certification of		ccurred at the time, date and place, a	and due to the cause(s) and manner as and at the time, date and place, and due t	stated. to the cause(s)
To the Ho within 24 To the Fu completely	one) 2 Medical Examiner: On the basis of examination and/or invest and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed	
	Mourain Mr. UGull-	O.C.M.E.	August 23, 20	009
	30. Name and address of person who completed cause of death (Item 23a)		D 04004	
		Penn Street, Baltimore, M	D 21201	
Stat	e 31. Date filed (Month, Day, Year) ALIG 2 6 2009 32. Registrar's Signature	arked		

Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

betted by Polymer Taning and The Polymer Taning and Taning an	PROCISE SHANTA Pacility Name (If not institution ASHINGTON ADVE ocial Security Number 19—08—8254 all Residence of Decedent State 10b. County 10b. County 10c. Street and Number 1998 MISSISSIPP Marital Status 1998 MISSISSIPP MARITAL MARITA	ARMSTRONG In give street and num NTIST HOSE I AVE. SE I Was Decendary of the street and recompleted I AVE. SE I Was Decendary of the street and recompleted I Yes, Give Year or Date of the street and recompleted College (1-4) WELL Inip (Type. Print) WELL / FA Sectify) Licensee	PITAL 7. Age (In yrs. 25 10c. Cit WAS Jent Ever in U. ces? 2 [X] No e tes: 40r 5+) ATHER atte Mt. 1000 P used the deatt	y, Town or Loc HINGTO S. 13. V 16a. Decec (Give life. I WAITR 19b. Mailin 4004 lace of Disposemetery, crem Olive	TAKOMA I If Under 1 Year Months Days action N 10f. Zip Code 20 Vas Decedent of Hir Yes, specify Cuba Pres 2 No ent's Usual Occupating of work done of NOT use retired ESS g Address (Street a MEADOWVIE sitton (Name of atory or other place)	OO20 ispanic Origin? (Sin, Mexican, Puerto Specify: atton furing most of word) 18. Mother's Name SANORA And Number or Rue W DRIVE e)	s. Date of Bir (Month, Da 10/24/ 10/24/ Decify Yes or No Rican, etc.) RMSTRON ral Route Numb. SUITLA Date	10, 4c. C MC thy, Year) 1983 10g. Citize UNITH 16b. Kinc PRI Maiden S G G ey, City or ND, M 20c. Loci	ED STAT. I. Race - Ameri Black, White, Specify: BLAC of Business/Ir VATE urname) Town, State, Zi ARYLANI atton - City or T	RY Inplace (State or Foreintry) Inington, D 10d. Inside City Limity 1X Yes 2 N Intry? ES Ican Indian, etc. CK Industry Ip Code) D 20746
betted by Physician/Medical Examiner Aa. Faral 5. Soo 57.0 Usual 10a. \$ 17. Faral 10a. \$ 17. Faral 19a. CHA 21. \$ 23a. Immediaea result Part II. 23a. Immediaea result Part II. Part III.	ASHINGTON ADVE ASHINGTON ADVE Cocial Security Number 79-08-8254 al Residence of Decedent State 10b. County Street and Number 798 MISSISSIPP Marital Status Michigan Married 15. Decedent (Specify only highes Identify Secondary (0-12) 11 Father's Name (First, Middle, Informant's Name/Relationsh MARLES J. FARE Method of Disposition Disposit	I AVE. SE I AVE. SE I AVE. SE I Lower Service of Armed Force I Lower Service of Serv	PITAL 7. Age (In yrs. 25 10c. Cit WAS Jent Ever in U. ces? 2 [X] No e tes: 40r 5+) ATHER atte Mt. 1000 P used the deatt	y, Town or Loc HINGTO S. 13. V 16a. Decec (Give life. I WAITR 19b. Mailin 4004 lace of Disposemetery, crem Olive	TAKOMA I If Under 1 Year Months Days action N 10f. Zip Code 20 Was Decedent of Hi Yes, specify Cuba Pres 2X No ent's Usual Occupating of work done of NOT use retired ESS g Address (Street & MEADOWVIE sitton (Name of atory or other place t	PARK If Under 24 Hrs. Hours Min. 0020 ispanic Origin? (S) In, Mexican, Puerte Specify: ation furing most of word 18. Mother's Nam SANORA A and Number or Ru EW DRIVE e) 8/17	secify Yes or No Prican, etc.) ecify Yes or No Prican, etc.) eting et	10g. Citize UNITI 16b. Kince PRI Maiden S G 20c. Loci	en of What Cou ED STAT Blace - Ameri Black, White, Gecify: BLAC d of Business/ir VATE urname) Town, State, Zi ARYLANI atton - City or T	RY splace (State or Forei intry) nington, D 10d. Inside City Limi Nayes 2 N Intry? ES ican Indian, etc. CK industry ip Code) D 20746
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Immedisearesult Sequence of the property of t	shock, or heart failure. List on nediate Cause (Final pase or condition	complications that cal	used the death		38 Marth					and 20747
pleted by Physician/Medical Examiner Seding Sample	nediate Cause (Final ease or condition	only one cause on ea	ch line	n. Do not ente					naryr	Approximate Interval Between
Sequence of the property of th	ease or condition ulting in death)		1	5 ~ 1	- A-					Onset and Death
Seducing Sed		Due to (o	or es a consequ	uen at of):	appric a	0.2				Ways
pleted by Physician/Medical Examin			200	6 3	isond-	en				4-cecrs
pleted by Physician/Medical	uentially list conditions,		a consequ							
pleted by Physician/Medical	se. Enter Underlying se (Disease or injury initiated events	c								
Part II.	Ilting in death) Last	Due to (o	r as a consequ	uence of):						
pleted by Physician/Me	,	d								
pleted by Physicia	EMALE:	23c If yes outer	ome of pregna	DOV						
pleted by	. Was decedent pregnant in the past 12 months?		rth 2□ Fetal ant at time of d	death 3	Ectopic pregnancy Other (specify)	/		23	ld. Date of deliv Month	very Day Year
pleted by	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknow		eau 5	Other (specify)					
<u> </u>	II. Other significent conditio	ns contributing to dea	ath but not resu	ulting in the un	derlying cause give	en in Part I.	23e. Did t	obacco us	contribute to	the cause of death?
0	Moxic Bra	in James	2/12	166	etes M.	स्।।भ छ	10'	∕es 2[]	No 3□ Pro	obably 4 🗆 Unknow
2 -	20 spinatore	Failure	e Ve	wife	tue Dea	140/208	24a. Was	an	24b. Were aut	opsy findings availab
, 				- (1)	100		eutor perfo	rmed?	prior to co death?	ompletion of cause o
0 25. W	Was case referred to medical					26. Place of Dea	1 Tyes		1 □Yes	2 ∐No
25. W ex o	examiner? 1∐-Yes 2∐ No	Hospital:	patient 2	EB/Outnatien	3□ DOA Othe	27.	ome 5 ☐ Resid		Other (Spec	(6.4)
₽ 27. Ma	Manner of Death	28a. Date of	finjury	28b. Time of	28c. Injury	/ at	28d. Describe I	-		(iy)
1 atio	☐ Natural 5 ☐ Pending		, Day, Year)	Injury	M 1 □ Y	?? Yes 2 □ No				
3[Полите	ot be 28e. Place o	of Injury - At ho	me, farm, stre	et, factory, office		28f. Location (S	Street and	Number or Rui	ral Route Number,
27. Ma 1E 21. 3. 3. 4. 4. 4. 4. 4. 4. 4. 4. 4. 4. 4. 4. 4.	B ☐ Suicide 6 ☐ Could n L ☐ Homicide determi	Dunung	g, etc. (opcon)	'/			City or Tov	vii, State)		
29a. C			est of my know	wledge, death	occurred at the timestigation, in my op	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)
29b. S	Homicide determine determi	g Physician: To the be examiner: On the bas and manne	sis of examinat	and and or an					signed (Month,	
	Certifier (Check only one) Signature and title of certifier	Physician: To the becaminer: On the bas and manner	sis of examinater stated.		29c. License				- 1	
30 NE	Certifier (Check only one) Signature and title of certifier	Physician: To the becaminer: On the bas and manner	sis of examinater stated.					Cerio	151 1	1 6009
15	Certifier (Check only one) Signature and title of certifier	Physician: To the becaminer: On the bas and manner	sis of examinater stated.					Ceva	1651 1	1 2009
State 31. Da	Certifier (Check only one) Signature and title of certifier	g Physician: To the baxaminer: On the baxand manner	sis of examinater stated.					CLU	te Mà	2009

		-	For State Registrar	of Maryland / De	epartment of F Certificate of L			liene eg. No. 🤈 🗍 🖺 📮	27361			
	Physicia	an	1. Decedent's Name (First, Middle, Last)	nco			2. Date of Deat Month	9, 2009 Year	3. Time of Death 04:02 M			
	/Medic Examin	al	HUGH MERCER ALEXAN 4a. Facility Name (If not institution, give street and		4b. City, Town, or	Location of Death	A00001	4c. County of Death				
ر			HOLY CROSS HOSPITAL		SILVER S		D. D. L. of Disth	MONTGOMERY				
	Funeral Director		5. Social Security Number 6. Sex 1 X M 2	7. Age (In yrs. last birtho	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month Day)	1922 VI	nplace (State or Foreign Intry) RGINIA			
	70		Usual Residence of Decedent	10c, City, Town o	r Location				10d. Inside City Limits			
	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Evanthar roust be notified at	- 1	MARYLAND MONTGOMERY	SILVER					1 □Yes 2 X □No			
	r 28a	Director	10e. Street and Number	<u>.</u>	10f. Zip Code		1	log. Citizen of What Cou	untry?			
	23a o	ral	13713 LOCKDALE RD.		20906			USA				
	items	Funeral	Arme	d Forces?	 Was Decedent of H If Yes, specify Cuba 	ispanic Origin? (Sp un, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White				
21215-0036	ours af	ğ	3 ☐ Widowed 4 ☒ Divorced If Yes	es 2 No 1945 TO Give or Dates: 1946	1 □Yes 2XINo	Specify:		Specify: BLA	NOK			
5-0	"natur	letec	15. Decedent's Education (Specify only highest grade complete	ed) (C	ecedent's Usual Occup Give kind of work done of fe. DO NOT use retired	during most of work	ing	16b. Kind of Business/I	ndustry			
712	within jiene. r than	Completed	Elementary/Secondary (0-12) Colleg	ne (1-4or 5+)	NITURE FINISH			FUNITURE REPA	NIR .			
nd	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evandant in at the multised at once.	Be C	17. Father's Name (First, Middle, Last)					Maiden Surname)				
Maryland	d Meni marked matic	P L	LUTHER ALEXANDER, SR. 19a. Informant's Name/Relationship (Type. Print)	10b N	Toiling Address (Street	CALLIE MA		r, City or Town, State, Z	(in Code)			
Ma	nd 2 sl alth an 27 Is r r traui		JEFFREY ALEXANDER (SON)	PRING, MD								
altimore,	es 1 al of Hea fitem rothe	·	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal fr	20b. Place of D	isposition (Name of crematory or other place			20c. Location - City or	Town, State			
ij	t. Pag tment tant: I		4 Donation 5 Dother (Specify)	CHESTNUT	GROVE BAPT. C			BRIGHTWOOD, VI				
Ba	permit Depar Impor any in	9	21. Signature of Funeral Service Licensee	W.C. THOMI PEPER, VA								
Q.	Physician (resulting in death)	on each line. DIORESPIRATORY AR	REST	ng, such as cardiac	or respiratory an	rest,	Approximate Interval Between Onset and Death MIN			
di	/Medical Examiner		Due to (or as a consequence of): SEPTIC SHOCK									
	p #	iner	Sequentially list conditions	e to (or as a conse uence of)					HRS			
	and and II-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
8760,	icate be executed physician and the burial-transit	dical	d									
O. Box 6	requires that the death certific been signed by the attending p hould be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		23d. Date of del Month	ivery Day Year						
Vital Records, P.	w requires that been signed b should be deta		Part II. Other significant conditions contributing ACUTE RENAL FAILURE	to death but not resulting in the	ne underlying cause giv	en in Part I.		obacco use contribute to res 2 ☐ No 3 ☐ Pr				
ecol	aw as b	Completed by	RT. SIDED HEART FAILURE				24a. Was a		utopsy findings available completion of cause of			
Ē.	: The law cate has b page 2 sl	Com	PULMONARY HYPERTENSION				perfor	med? death?	2 □ No			
Zit2	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital:	MILL PLANS OF THE PARK	ationt 3 DOA Oth	26. Place of Dea			~ .			
of	ing Phys After this uneral di	ion: To	27. Manner of Death 1 X Natural 5 Pending	1 ☑ Inpatient 2 ☐ ER/Outp Date of Injury Month, Day, Year) 28b. Tin Inju	ne of 28c. Injury	ry at k?		lence 6 □ Other (Spe now injury occurred	city)			
Division	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	Certification: To	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. F	lace of Injury - At home, farm building, etc. <i>(Specify)</i>		Yes 2 □No	28f. Location (S City or Tow	Street and Number or Run, State)	ural Route Number,			
	To the Hospital or within 24 hours afte To the Funeral Director completely filled in I	Medical C	29a. Certifier 1 Certifying Physician: T (Check only one) 2 Medical Examiner: One and									
	To th within To the	Me	29b. Signature and title of certifier		29d. Date signed (Mont	h, Day, Year)						
	1+1	1 D 0068096 AUG. 10, 2008										
1	2011		30. Name and address of person who completed	cause of death (Item 23a) (Ty ST GLEN RD., SIL)		20910						
	Sta	te	SATYAM A. SHAW 1500 FORE 31. Date filed (Month, Day, Year) AUG 1 3 2009	32. Registra's Signature	/ OF THE VO. 17L	, 20030			· ·			
	Registr		AUG 1 3 2009 Gener	D. 19 ave								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 08 **Physician** 2136P M Jane Rosalie Adams 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) **Examiner** If Under 1 Year Date of Birth (Month, Day, Year) 03/16/1933 Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday) Funeral Days Country)
Maryland Months 214-28-4847 1 □ M 2 🔀 F 76 Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene.

m 27 is marked other than "natural", or items 23a or 28a-f show her traumatic event, the Medical Exammer met two redified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐Yes 2 ☐No Funeral Director Salisbury Maryland Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21801 USA 6412 Freedom Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: white Completed by 3 ☐ Widowed 4 🔀 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) caregiving 9 caregiver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Freda Drieslein Horace Souder 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6412 Freedom Way, Salisbury, MD 21801 Teresa Engle/daughter Health tem 27 i item 2 Pages 1 ament of H 20a. Method of Disposition 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) permit. Pages
Department of
Important: If it
any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 8/11/09 Salisbury, MD Salisbury Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility HOLLOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** CAD /Medical Due to (or as a consequence of): Examiner HF Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed lare Renal burial-tran and Due to (or as a consequence Box 68760 physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Dav ρ Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform 2 No 1 ☐Yes Physician; 25. Was case referred to medical 26. Place of Death (Check only one) funeral director Be examiner? Hospital: Other: 4 \sum Nursing Home 5 \sum Residence 6 \subseteq Other (Specify) 1 Yes 2 ₩No Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar DHMH 17 Rev 1/2001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatu

Das,

Sal

31. Date filed (Month, Day, Year)

D57952

106 Milford ST. # 504B. Salisbury, MD 21804

08/11/09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2 Date of Death 3. Time of Death Day Year 09 Month 21:01 4c. County of Death Name (If not institution, give street and number) 4b. City, Town, or Location of Death fimere If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Year) Days Months Hours 1**⊠** M 2□ F 581-15-8277 50 10/14/1958 Puerto Rico Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10h County 10a. State 1 ☐ Yes 2 🔀 No Salisbury Maryland Wicomico 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 5531 E. Nithsdale Drive 21801 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1XIYes 2□No Specify: Puerto Rican hispanic Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) peditrician health care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Julita Alonso Frankie Alvarado 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sylvia Alvarado/spouse 5531 E. Nithsdale Dr., Salisbury, MD 21801 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State Salisbury Crematory 8/12/09 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Europeal Service Holloway funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 1. Enter the disease, or complications the called the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death iate Cause (Final se or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

9

Completed

Be

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exyminar must be notified at

filed within 72 hours after i Hygiene.

and Mental Hygiene.

Department of Health ar Important: If item 27 is any injury or other trau

Pages 1 and 2 should be

3altimore, Maryland 21215-0036

Examiner physician and s the burial-trans attending p been signed by the should be detached

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requires that the death certificate be executed

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Box 68760.

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Records,

Division of Vital

Physician/Medical by Completed Be Certification: To

To the Hospital or Attending Physician: death. within 24 hours after death

To the Funeral Director:

completely filled in by the f

Medical State Registrar

certificate has b After this c

> nth, Day/ 31. Date tired (Mo

25. Was case referred to medical

5 Pending

investigation

determined

6 ☐ Could not be

1 Yes 2 □ No

examiner

27. Manner of Death

1 🗌 Natural

2 Accident

3 ☐ Suicide

4 - Homicide

(Check only one)

29b. Signature and title of certifier

30. Name and advest of person who

unleted caus death (Item 23a) (Type, Print) South 32. Registrar's Signature

28a. Date of Injury (Month, Day, Year)

72009

1 npatient 2 ER/Outpatient 3 DOA

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

77

Koadway

Street Baltomere

28c. Injury at Work?

🛮 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐Yes 2 No

2 No

28d. Describe how injury occurred

Vohicle

Location (Street and Number or Rural Route Number, City or Town, State) R+50 NEGY Main St

29d. Date signed (Month, Day, Year)

1 Tyes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

ORIGINAL

DHMH 17 Rev 1/200

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 10:25 pM 07 2009 Edwarda Louise Auhust 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Montgomery Brooke Grove Nursing Home Sandy Spring Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Hours Months 1 □ M 2 🕱 F Days 93 November 15, 1915 579-30-9983 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 K No Prince George's Adelphi Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20783 U.S.A. 9717 Riggs Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Tyes 2 X If Yes, Give Year or Dates: 2 X No 1 Never Married 2 Married 1 □Yes 2 No Specify Specify: 3 X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Prince George's County College (1-4or 5+) Elementary/Secondary (0-12) Public School System School Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Irvin Edward Michael Teresa Margueritte Atkinson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Elizabeth B. Koby - Daughter 16201 Whitehaven Road, Silver Spring, Maryland 20906 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) 08/12/2009 Gate of Heaven Cemetery Silver Spring, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hines-Rinaldi Funeral Home, Inc. Na 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Approximate Interval Between Onset and Death 23a. Part 1. Enter the dise shock, or heart failur ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate use (Final disease or condition resulting in death) 141 Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): yes, outcome of pregnancy Live birth 2 Fetal death Fregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? ditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 1 Yes 26. Place of Death (Check only one) Hospital:

Physician /Medical **Examiner**

Examine and burial-trai

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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Funeral

Director

?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, The Medical Examinar must be notified at

of Health and Mental Hygiene.

permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tr. once.

Pages 1 and 2 should be

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

ed by the attending physician detached for use as the buria Physician/Medical cate has been signed by page 2 should be detach ģ Completed within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

	ıc
BREAST	

25. Was case referred to medica
examiner?
1 ☐ Yes 2 ☐ No
101.00

1 Natural

2 Accident

3 Suicide

27. Manner of Death 5 Pending investigation 6 ☐ Could not be

determined

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 28b. Time of

28c. Injury at Work? 1 🗆 Yes

29c. License number

Other: 4 Arring Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

	one)			
29b.	Signature	andtitle	of	cert

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

ANURA DHA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SILVER STE 209, 1030

and manner stated.

State Registrar

Medical

e Funeral I

To the within 2

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P.O. Box 68760, Division of Vital Records,

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** AUGUST 1, 2009 **JAMES** 3:10 A M **BLAKE-LOBB** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner CROFTON CONVALESCENT CENTER ANNE ARUNDEL CROFTON 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)

NEW YORK 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 X M 2 ☐ F 88 NOV.18,1920 057-18-1083 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h. County 10c. City, Town or Location 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 Xes 2 No Funeral Director MD ANNE ARUNDEL DAVIDSONVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ 1309 LAVALL DRIVE items 23a 21035 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No WWII 14. Bace - American Indian. Black, White, etc permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other any injury or other. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Be Completed by If Yes, Give Year or Dates: **KOREA** Specify: WHITE 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) PILOT US GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) WALTER BLAKE-LOBB MARION PHILLIPS 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VERA LYNN BRADY/ DAUGHTER DAVIDSONVILLE, MD 21035 1309 LAVALL DRIVE 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State MEADOWLAWN MEMORIAL NEW PORT RICHEY, FL 8/6/2009 4 ☐ Donation 5 ☐ Other (Specify) GARDENS 21. Signature of Funeral Service Lice 22. Name and Address of Facility ROBERT E. EVANS FUNERAL HOME 16000 ANNAPOLIS ROAD BOWIE, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and mipletely filled in by the funeral director, page 2 should be detached for use as the burlat-transit mipletely filled in by the funeral director, page 2 should be detached for use as the burlat-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Advanced Dementia 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed Debilitation 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 2 Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 📈 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours the Funeral Dire 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely within 2 and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 08/03/2009

Defense that, Crofton, MD21114 29b. Signature and title of certifie Name and address of person who completed cause of death (Item 23a) (Type, Print) (x) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month Year **7:**02 a ^M Barbara H. Burgher August 04 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Carroll Hospice Dove House Westminster If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 X F 75 069-28-8823 Director Apr 06 1934 NYC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show 10a, State 10b. County iral", or items 23a or 28a-f sho 1 ☐ Yes 2 X No Funeral Director Hampstead Carroll MD the 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 21074 USA 3405 Schaeffer Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1∐Yes 2∐No þ If Yes. Give Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineering Dept Telemecanique item 27 is marked other other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alexander R. Halliday Edith Ettershank ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 949 Rolling Ridge Drive Westminster, MD 21157 Karen Hersh/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 08/0772009 permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Evergreen Memorial Gardens Finksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Printen Pareration Home and Chapel, P.A. 21157 412 Washington Road Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease of Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan: The law requires that the death certificate be executed Exami and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 2 No 3 Probably 4 Unknown 1 □ Yes Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 🗆 No 1 ☐ Yes 2 **X** No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) Hospice 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Attending 1 Natural 5 Pending death. To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

WJL 10

> State Registrar

29b. Signature and title of certifit

Herbert

P. Hend

31. Date filed (Month, Day, Year)

7

2973

completed cause of death (Item 23a) (Type, Print)

MO

Manchest

29c. License number

Mancheston

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ME 8896 10/1/09 TT

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** M 0500 John T. Brooks 2009 10, /Medical August 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's C1 inton Southern Maryland Hospitol If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Country) OH Days Hours Months Min. 0173071963 Yrs. Director 281-62-5269 Usual Residence of Decedent 10a. State 10d. Inside City Limits 10c. City, Town or Location 10b. County show if than "natural", or items 23a or 28a-f sho 1 X Yes 2 ☐ No Director Cheltenham Prince George's MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10210 Marlboro Woods Drive 20623 USA Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or items 23 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🛣 No Specify Specify: Black \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Systems Analyst IRS/Federal Government 6 12 Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Semoria Brown Noah Brooks ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carla M. Brooks/Wife 10210 Marlboro Woods Dr., Cheltenham, MD 20623 or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/18/2009 | Cheltenham, MD Maryland Veterans 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd., Camp Springs, MD 20748 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Hanging /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Box 68760, attending physician Physician/Medical as the IF FEMALE: nse yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached fi P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ icate has been siç r, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Hypertension Completed Was a autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Bipolar Disorder 24a. Was an The certificate 1 ☐ Yes 2 🗆 No 1 □Yes Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Certification: To this To Time of Injury : 17 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending am 1 □Yes 2 X No al or Attendin s after death. Hung himself with cord 08/10/2009 investigation 2 Accident the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 10210 Marlboro filled in by 4 Homicide Woods Dr., Cheltenham, MD 20623 Home To the Hospital within 24 hours a To the Funeral (Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salvador Sylvester, 3001 Hospital Drive, Cheverly, MD 20785 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 3 2009

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month Physician p^M 6:30 Josephine Roone 8 2009 Aug /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's Prince George's Hospital Cheverly If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday, 5. Social Security Number **Funeral** Days Hours Months 1 □ M 2 X F 73 New York 116-28-4738 Jul 10 1936 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County "natural", or items 23a or 28a-f show idical Examiner must be notified at 1★ Yes 2 No Director MD Prince George's Bowie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20721 2011 Golden Morning Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Never Married 2X Married **Black** Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Government Librarian event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be fill Health and Mental H em 27 Is marked oth Be Eva Basnight Joseph Carnan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If Item 27 Is many injury or other 2011 Golden Morning Drive, Bowie, MD 20721 Danette Boone/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Aug 18 2009 White Plains, NY 4 ☐ Donation White Plains Ceme 5 Other (Specify) 22. Name and Address of Facility J.B. Jenkins Funeral Home 21. Sign hure of Juneral State Licensee 4 7474 Landover Road, Landover, MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final minutes **Physician** Acute Ventricular Fibrillation disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner hours Acute Myocardial Infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed years Diffuse Coronary Atherosclerosis iding physician and se as the burial-trai Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d Date of delivery 23b. Was decedent pregnant atten for us 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Day Month Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) □Yes 2 X No Ö the 9 Unknown signed by t ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ History of Rheumatic Heart Disease with mitral and 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? tricuspid valve replacement, Diabetes Mellitus 24a. Was an page 2 s has performed? certificate non-insulin dependent, Hypertension 2 No 1⊠ Yes 2□No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 图 Natural 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: (Month, Day Year) or Attending 5 Pending investigation after death.

I Director; Af din by the fundament 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide hours after filled in e Funeral I Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier m() D24720 August 8, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ravinder K. Rustagi 6132 Landover Road, Cheverly, MD 20785 AUG 1 3 2009

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year 2320 FM David ameron one 2009 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Agnes Hospital altimore xaint If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) Cary land 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 1**X** M 2□ F Months Davs None June 04 2009 2 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 Yes 2 □ No Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4617 Road States Rokebu 21229 United by Funeral Was Decedent Ever in U.S. Armed Forces? 1 Yes No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Never Married 2☐ Married 1 Tes Tiles 1 Yes, Give Year or Dates: 1 □Yes 2 No Specify Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) HONE infant intant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David Lamont ပ Nakeya onuell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or - ral Route Number, City or - n, State, Zip Code) Donyell Strickler/Mother 4617 Road Rokeby Baltimore Maryland 20c. Location - City or Town, State 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date October 2 2007 Burial 2 Cremation 3 Removal from State Cathodral Cementary Baltimore Maryland 4 □ Donation 5 □ Other (Specify) New A CHES HOSPITAL 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ST 900 CATON AVENUE LAND sen Der adria 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Prematurit Extreme Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: yes, outcome of pregnancy Live birth 2 D Fetal death Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □Yes 2 □No 2 Accident

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending abusing most burial-tran Box 68760, attending physician for use as the buria P.0. cate has been signed by the page 2 should the detached Division of Vital Records, director,

Certification: To funeral filled in by the

3 Suicide

29a, Certifier

one

30. Name and add

4 Homicide

(Check only

29b. Signature and title of certific

Funeral

Director

s 23a or 28a-f show ust be notified at

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

? is marked other than "natural", or items traumatic event, the Medical Examinating in

of Health and M fitem 27 is man r other traumat

permit. Pages
Department of Important: If it any Injury or o

Physician

/Medical

Examiner

completely

State Registrar

Medical

Pickett MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) AUG 2

6

6 Could not be determined

2 Medical E

cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

AUGUST 13, 2009

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

4 E. Rolling Crossroads Suite 110 Catonsville Mary land

🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

partier: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D606182

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 2113 P^M 2009 Joan MacAllister Brockell August 19 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union_Hospital Cecil Elkton 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F Months Director JAN 15, <u>410-82-7170</u> 60 1949 Massachusetts Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, its Profice Eventral must be reallful at Director 1 ¥Yes 2 □ No Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 416 Melbourne Boulevard 21921 United States Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?
1 ☐ Yes 2 📉 No within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No If Yes, Give Specify. ð Specify: 3 Widowed 4 Divorced Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Budget Administrator County Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Russell H. MacAllister Mary Frances Maguire 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s. Department of Health ar Important: If item 27 is any Injury or other traus Charles Richard Brockell, Jr./Husband 416 Melbourne Boulevard, Elkton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gilpin Manor Memorial 20a. Method of Disposition Date 20c. Location - City or Town, State August 24, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Park Elkton, MD 21. Sign aure of Funeral Service Licensee Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Renal **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, If a year of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last iner law requires that the death certificate be executed Exam -nflue and Due to (or as a consequence of): burial attending physician for use as the burla Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 💽 Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Impatient Medical Certification: To this After this funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner eath 28b. Time of 28d. Describe how injury occurred 1 Tatural 5 Pending To the rospiration 24 hours after death.

To the Funeral Director: Af investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Box 68760, P.O. Vital Records, of Division To the Hospital or Attending

> State Registrar

29a, Certifier

(Check only one

29b. Signature and title of certific

AUG

His Year

DHMH 17 Rev 1/2001

ORIGINAL

and address of person who completed cause of death (Item 23a) (Type, Print)

Elkton

Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

044716 José Ma, M.D. 29d. Date signed (Month, Day, Year)

2009

		For State Registrar		State	of Maryl	land / D	epartn <i>Certifi</i>	nent of <i>cate o</i> a	Health f Death	and N	Mental Hy	giene Reg. No.	200	9 2	7372
Dhusisi		1. Decedent's Name	(First, Middle	e, Last)							2. Date of De	eath Day	Year	3. Time	e of Death
Physici /Medic			F	onald Fra	ncis C	onley,	Jr.				August	08	2009	6:	:54 p ^M
Examir	ner	4a. Facility Name (If	not institutior	, give street and n	umber)		4b.	City, Town,	, or Location	of Death		4c. C	ounty of Deat	th	
and the same of th				Hospital	T- 1 (1)	. 7. 1653	()	Si Jnder 1 Yea	ilver Sp		C Data of Bi			gomery	As an Faustina
Funeral		5. Social Security Nu		6. Sex 1 ▲ M 2 ☐ F		yrs. last birt		nths Day		Min.	8. Date of Bir (Month, D	ay, Year)	Co	ountry)	te or Foreign
Director		526-21-57 Usual Residence of D				53					November	18, 19	.55	Florida	i .
land ow			10b. County		10c	. City, Town	or Location	n						10d. Inside	e City Limits
Mary F sh	to	Maryland	Mor	tgomery				Si1	lver Spi	ring				1 □ Y	es 2₺No
r 282	Director	10e. Street and Num					10	of. Zip Code				10g. Citize	n of What Co	ountry?	
h witi 23a o			1314 Mi	mosa Lane					20904				U.S.	Α.	
parifiliore, Marylating AIAID-0000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Medical Examination is be recitived at once.	Funeral	11. Marital Status		12. Was De Armed F	cedent Ever i	in U.S.	13. Was I	Decedent of	f Hispanic Or uban, Mexica	rigin? (Sp	pecify Yes or No Rican, etc.)	0- 14	Race - Ame		i,
afte or it	by Fu	1 Never Marrie		ied 1 □Yes If Yes, 0	2 ₹ No Give			es 2. N					pecify:		
iural 60		3 ☐ Widowed 4		Year or	Dates:	160	Decedent's	Usual Occ	unation			16h Kind	of Business	White	e
n 72 "nal	Completed	(Specif	y only highe	t's Education of grade completed			(Give kind		ne durina mos	st of work	king	l lob. Killo	TOT DUSTILESS/	maustry	
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Hilled Hyg Sther ent,	Be C	17. Father's Name (F	irst, Middle,				op zouz				ne (First, Middle				,
d be ental ked c	To B	F	Ronald E	rancis Con	lev. Sr						Joan Ann	Burns			
shou ind M imar umat	-	19a. Informant's Nar					Mailing Ad	dress (Stre	et and Numb	er or Ru	ral Route Numb	per, City or T	Town, State, .	Zip Code)	
Nd 2 alth a 27 is r tra		Sharon L.	Conley	- Spouse		1	314 Mi	nosa La	ane. Sil	lver S	Spring, M	arvland	20904		
s 1 and 2 ard Health a litem 27 is		20a. Method of Dispo	osition	-	- 1	0b. Place of	Disposition		1		Date		ation - City or	Town, State)
diffillor rmit. Pages partment of portant: If if y injury or or		1 🔀 Burial 2 □ 4 □ Donation 5		3 🗷 Removal fror p <i>ecify)</i>		\			metery	08/1	4/2009	Chand	ler, Ari	izona	
mit. mit. porta		21. Signature of Fun	eral Service	Li ense		4	22. Na	me and Add	dress of Facil	ity					
Dermi Depar Import	1. 1	Nama	1 1	. De a		/ Lu					Home, Inc enue, Sil		ring, Ma	ryland	20904
		23a. Part1. Enter the shock, or heart	isease, or	complications that	caused the	death. Do n	ot enter the	e mode of d	lying, such as	s cardiac	or respiratory	arrest,		Approxi Interval	mate Between
Physician		Immediat Cause (F	inal		eroscle									Onset a	ind Death
/Medical		resulting in death)			o (or as a cor			usculai	DIBCAR	,,,					
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D #	Examiner	if any, leading to imm	nediate	Due to	o (or as a cor	nsequence o	of):								
ecute and -trans	am	Cause (Disease or in that initiated events resulting in death) La	njury '	c	- /										
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the first	edical			d	·										
eath certific attending p		IF FEMALE:		23c If yes o	utcome of pr	ednancy						0.0		lie en en e	
eath ce attendii for use	sician/M	23b. Was decedent p in the past 12 m	nonths?	1 Liv	e birth 2 🗆	Fetal death		opic pregna er <i>(specify)</i>				23	d. Date of de Month	Day	Year
the d	ıysi	1 ☐ Yes 2 ☐ 9 ☐ Unknown	No	9 🗆 Un		or death	3 🗆 Ош	er (specify)							
that hed by deta	/ Phy	Part II. Other signific	cant condition	ons contributing to	death but not	t resulting in	the underly	ying cause (given in Part	l.	23e. Did	tobacco use	e contribute to	o the cause	of death?
v requires to been signer should be co	d by										1 🗆	Yes 2□	No 3□P	robably 4	Unknown
v req	Completed										24a. Was	s an	24b. Were a	utonsy findi	ngs available
ne lav e has ge 2	m d										auto		prior to death?	completion	of cause of
n: Ti n: Ti fiicate or, pa		25. Was case referre				<u>-</u>					1 □ Yes	2 K No		2 □ No	
sicert irectc	Be	examiner?		Hospital: 4 F	7 Innations	0 5 ED/0			Other		th (Check only		To::		
ding Physician: The Inding Physician: The Inding Physician: The Inding Ind	. To	27. Manner of Death		28a. Dat	Inpatient e of Injury	28b. T	ime of			ursing H	ome 5 ☐ Res 28d. Describe			ecity)	
Affer Paris	ţjo	1 ☑ Natural 2 ☐ Accident	5 Pendin investig	9	onth, Day, Yea	ar) Ir	njury N	28c. In W	/ork? □Yes 2□]No					
Atter dea	fica	3 Suicide	6 ☐ Could i	ant ho	ce of Injury - A	At home, far	m, street, f	actory, office	e	-	28f. Location	(Street and	Number or R	ural Route I	Vumber,
affer Direction	Certification:	4 Homicide	dotoiiii	buil	ding, etc. (S)	pecity)					City or To	wn, State)			
To the Hospital or Attending Physician: The law requires that the death certifulin 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as				g Physician: To t											(-)
he Ho in 24 he Fu	edical	(Check only 2 one)	z wedical	Examiner: On the and ma	anner stated.	mination and	a/or investi	yallori, in m	y opinion, de	ain occu	rred at the time	, date and p	ariace, and du	e to the cau	se(s)
To 1 To t	Σ	29b. Signature and ti	tle of certifie		In			29c. Lice	ense number 243	40		29d. Date	signed (Mon		
70		1 He		5/	د. –			+	1-13	CA			8,08	1.200	7
, ,		30. Name and addres	ss of person 子といとい		term		43		est Gler	n Road	i, Silver	Spring	g, Maryl	and 209	910
Sta Registr		31. Date filed (Month	1 2 2	La Company	Registrar's S	Signature	all	ē.							

Amended Item 23a Part I Line b, Per Phy. 08/07/2009 Carroll Co., wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2009 7:13 a M August 04 Arlene Doris Clark /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospice Dove House Carroll Westminster If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) June 18 1937 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M **X**□ F Months Days Hours MD **Director** June 215-34-0881 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location ortant: If item 27 is marked other than "natural" or items 23a or 28a-f show injury or other traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2 ☐ X 0 Director Westminster MD Carroll 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21157 315 Kolbe Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 □ No Specify White Specify: þ 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Item 100 Elementary/Secondary (0-12) College (1-4or 5+) Carroll County Times 12 Human Resources 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Doris Brooke Wicklein Walter Anderson Blottenberger ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 315 Kolbe Road Westminster, MD 21157 Maurice Clark, Sr/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 08/07/2009 Westminster, MD Meadow Branch Cem 4 Donation 5 Dother (Specify) of uneral Service License Princes Afferial Fally Home and Chapel, P.A. 21157 412 Washington Road Westminster, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 3 days Immediate Cause (Final disease or condition resulting in death) ta. lvre **Physician** /Medical Due to (or as a consequence of Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and sician and burial-transit Due to (or as a consequence of): P.O. Box 68760 Completed by Physician/Medical as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) ☐Yes 2-No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ☑No 24a Was an page 2 autopsy performed? Yes 2 2 No 1 ☐ Yes Division of Vital Be funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice 2 No Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Anatural in 24 hours after death.
The Funeral Director: Aft 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in my original death. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of ce WIZ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 0

DHMH 17 Rev 1/2001

Registrar

			- FOI	partment of Health and Mental F ertificate of Death	Reg. No. 2 1 1 9 2 7 3 7 4			
	Dhysiai	.	Decedent's Name (First, Middle, Last)	2. Date of Month	Death 3. Time of Death			
100	Physici /Medic		MARIE BROOKS COLEMA		09 2009 0425			
	Examin	er	4a. Facility Name (If not institution, give street and number) GREATER LAUREL HOSPITAL	4b. City, Town, or Location of Death LAUREL	4c. County of Death PRINCE GEORGE'S			
name (C)	Funeral	A	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. 8. Date of	Birth 9. Birthplace (State or Foreign			
	Director		577-54-9641 1		Day, Year) Country) 12 1931 VIRGINIA			
	yland how at		10a. State 10b. County 10c. City, Town or	Location	10d. Inside City Limits			
	e Mar 3a-f sl tiffied	ctor	MD PRINCE GEORGE'S LAURE		1 May Yes 2 No			
	vith th	Dire	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?			
	eath v	eral	9000 BRIARCROFT LANE # 138 11. Marital Status	20708 3 Was Decedent of Hispanic Origin? (Specify Yes or	USA No- 14. Race - American Indian,			
21215-0036	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	by Funeral Director	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No 1 ∀es 2 □ No 1 ∀es (3 □ Yes 2 □ No 2 ∀es or Dates:	Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) □ Yes 2 X No Specify:	Black, White, etc. Specify: BLACK			
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121	filed within Hygiene. other than '	dmo	Elementary/Secondary (0-12) College (1-4or 5+)	CARE PROVIDER	PRIVATE			
9	illed Hygi other ent, t	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Midd				
ılan	S should be filed and Mental Hygi is marked other aumatic event, t	To B	PEYTON YANCEY	NELLIE KENN	EY			
Baltimore, Maryland	nd 2 s Ith ar 27 is r trau	•		illing Address (Street and Number or Rural Route Nu77 NEWTOWN ROAD NEWTOWN,				
more	Pages 1 ar ent of Hea nt: If Item 3 ry or other		1 VI Burial 2 Cremation 3 Removal from State	position (Name of rematory or other place) N MEM. GARDENS 8/15/2009	20c. Location - City or Town, State HANOVER, VIRGINIA			
Balti	permit. Pages : Department of H Important: If ite any injury or of		21. Signature of Funeral Service Licensee	22. Name and Address of Facility J. B. 7474 LANDOVER ROAD LANDO	JENKINS FUNERAL HOME VER.MARYLAND 20785			
r			23a. Part1. Enter the disease, occomplications that caused the death. Do not eshock, or heart failure. List only one cause on each line.					
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	uted d ansit	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					
oʻ	an an	Еха	resulting in death) Last Due to (or as a consequence of):					
68760,	ficate be executed physician and s the burial-transit	edical	d					
Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me		3 □Ectopic pregnancy 5 □ Other (specify)	23d. Date of delivery Month Day Year			
, P.O	res that t signed by be detac		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I. 23e. D	id tobacco use contribute to the cause of death?			
ords	w requires been sign should be	ed by	COPD ARTHRITIS	1	☐ Yes 2☐ No 3☐ Probably 4 ☐ Unknown			
or Vital Records,	The law re ate has be page 2 sho	Completed			utopsy prior to completion of cause of death?			
/ita	iclan: The certificate har rector, page	Be C	25. Was case referred to medical examiner?	26. Place of Death (Check or				
Or/	Physl this o	To.	1 ☐ Yes 2 No Hospital:		desidence 6 Other (Specify)			
on	nding P h. After funera	tion	1 Natural 5 Pending (Month, Day Year) Injur		be how injury occurred			
Division	l or Attendi after death. Director: #	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)		on (Street and Number or Rural Route Number, Town, State)			
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 28a. Date of Injury 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28b								
	To the To the To the To the Complex co	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)			
	4.=		> Pricar	D28998	Ay09 2009			
R	10		30. Name and address of person who completed cause of death (Item 23a) (Type G101 Chorry Lene Sur	le 211 Lourd	5A1M/ 20708			
	Sta Registi		30. Name and address of person who completed cause of death (Item 23a) (Type 2 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2					

imothy Wayne (1	1- For State Certificate of Death
Physicia	ın/	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year
Medical Examir		Timothy Wayne Clark 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
		17124 KIng James Way #201 Gaithersburg Montgomery
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Washington 1953 Foreign Washington 1953 195
Director		560-90-4693 1X M 2 F 56 Yrs. Months Days Hours Min. February 3, Foreign Washington Country) D.C.
any	F	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
* .		Maryland Montgomery Gaithersburg
Maryland 28a-f show d at once.	01	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
with the Maryland ns 23a or 28a-f sho be notified at once		17124 King James Way; Apt. 201 20877 United States
0036 within 72 hours after death with the Maryland gione. rer than "natural", or items 23a or 28a-faite Medical Examiner must be notified at once	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 3. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 4. Race - American Indian, Black, White, etc.
er dea		1 Yes 2 X No 3 Widowed 4 X Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: Black
ours afi	d b	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry
6 172 hc an "na	lete	Elementary/Secondary (0-12) College (1-4 or 5+) WOTIG RECYCLEG
5-003 iled withir Hygiene. J other th	Completed	11th grade Truck Driver Trucking Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
21215-0036 uld be filed within 72 hou Mental Hygiene. marked other than "natic event, the Medical Exa	Bec	Franklin Ivory Clark Josephine Elizabeth Brannon
2121 tould be fill d Mental It is marked tic event, t	P	19a. Informant's Name/Relationship (Type, Print) (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20748
MD nd 2 st alth an m 27 i		Lucretia Aleather Clark-Alston 3438 Brinkley Road; Apt. 302; Temple Hills, Maryland 20a. Method of Disposition (Name of cemetery. Date 20c. Location - City or Town, State
Ore,		1 Burial 2 A Cremation 3 Removal from State crematory or other place) Aug. 25, 2009
ltim it. Pag riment riment: y or o		4 Donation 5 Other Specify: Chesapeake Crematory, Inc. Beltsville, Maryland 22. Name and Address of Facility R. N. Horton Company Morticians,
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatite er	1	Inc.; 600 Kennedy Street, N.W.; Washington, D.C. 200
Physician	1	3a. Part I. Enter the dil ease, or complicati ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and
/Medical xaminer	. 0	Immediate Cause (Final disease a Acute amitriptyline intoxication
		or condition resulting in death) Due to (or as a consequence of):
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):
iO, te be executed ysician and burial - transit		d. 23a,2/,28a-t,perME, g894 8/31/09 TT
O, e be exe ysician burial -	ledical	X UNPENDED AMENDED
876(ifficate ng phy is the b	M/U	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year
Box 6876 e death certificate the attending phy ed for use as the l	sician/M	past 12 months? 4 Pregnant at time of death 5 Other (Specify)
the dea	Phys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
, P.O. res that the signed by be detack	b	1 Yes 2 ✔ No 3 Probably 4 Unknown
Division of Vital Records, tal or Attending Physician: The law require rs after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	Completed	24a. Was an autopsy findings available autopsy prior to completion of cause of
eco he law ite has	dmc	performed? death? 1 Yes 2 ✔ No 1 Yes 2 No
tal Rec	BeC	25. Was case referred to medical 26.Place of Death (Check only one)
Vit	To E	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other; 4 Nursing Home 5 Residence 6 V Other: Scene 28a. Date of Injury 28b. Time of Injury at Work? 28d. Describe how injury occurred
n of ding Ph. h. After t		1 Natural (Month, Day, Year)
isio Atten er deat rector by the	icati	2 Accident Investigation Fd 8/14/U9 Fd 12:30 PIII
Division pital or Attent ours after death teral Director: filled in by the	Certification:	Suicide 4 Homicide Homicide Homicide Activities and state of the property of t
		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
To the Hos within 24 h To the Fur	Medical	One) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Sirmature and title of certifier() 29c. License number 29d. Date signed (Month, Day, Year)
	Σ	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 15, 2009
		30. Name and address of person who completed cause of death (Item 23a)
1		Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
	tate	
Regis		4 ATTE V 1 /10194

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Wendy Pandora Crosell 16 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Regional Medical Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Months Days Hours Min. 1 □ M 2 🔽 F 49 216-70-5565 Oct 2. MD Usual Residence of Decedent 10b County 10c. City. Town or Location 10d Inside City Limits 1 ¥ Yes 2 □ No Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 425 Truitt Street 21801 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1

Never Married 2 ☐ Married 1 □Yes 2 No Specify Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) n/a n/a 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James E. Crosell Eunice S. Price 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alisha S. James-Collins/daughter 425 Truitt St., Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Salisbury Crematory Aug 14,2009 Salisbury, MD 22. Name and Address of Facility Lewis N. Watson Funeral Home, PA ULSON 1618 West Rd., Salisbury, MD 21801 Approximate Interval Between Onset and Death volustas notos otas cult Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 □ Yes 2 1NO 26. Place of Death (Check only one) Hospital 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

MD

Funeral

Director

28a-f show

Director

Funeral

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Completed

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "hedical Examinar must be notified at

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permit. Pages 1
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Important: If ite
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Pages 1

72 hours after

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Division of Vital Records,

Physician:

or Attending

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law requires that the death certificate be executed funeral director, After this s after dea. ral Director: Aftr filled in by Hospital within 24 hours a Fo the Funeral I

Be

Medical Certification: To

31. Date filed (Month, Day,

Year

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21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Completed 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 🔲 No 2 Accident 6 ☐Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signatu 29d. Date signed (Month, Day, Year) 30. Name and address of pe o completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

32. Begistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Ronald Clark 47PM Jay /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Wicomico at the lisbur oastal Hospice If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday)
51 Yrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1**X** M 2□ F 228-82-5995 Director Washington, DC 05/03/1958 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Evaminer must be notified at 1 ☐ Yes 2 X No Director Wicomico Maryland Salisbury 10g. Citizen of What Country? 10e. Street and Number 21804 USA 507 Regency Drive by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 TNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4or 5+) technical engineer Hardin-Kight 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. Mary V. Grove Clyde A. Clark ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 507 Regency Dr., Salisbury, MD 21804 Teresa L. Clark/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 8/11/09 Salisbury Crematory Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furréral Service License Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician UNG NCRR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) for use as the burial-transi resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician The law requires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death signed by the a d be detached for 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 3☐Probably 4☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autops, performed A certificate 1 □Yes 1 ☐ Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Other (Specify) After this 28a. Date of Injury (Month, Day, Year) 27. Manuer of Death 28b. Time of Injury 28d. Describe how injury occurred of or Attending Parter death. Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C To the Hospital

Registrar DHMH 17 Rev 1/2001 29a. Certifier

(Check only one)

6 Hulston

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)
AUG 1 1 2009

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BOX

gistrar's Signature

Medical

CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D0058410

Stasbury

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician 4:15 P.M. George Edward Dashiell, Jr. 4 2009 August /Medical 4h City Town or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Anchorage Nursing & Rehabilitation Center | Cocial Security Number | 6. Sex | 7. Age (In yrs. last birthday) | If Under 1 Year Salisbury If Under 24 Hrs. Wicomico Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Funeral Months 1 X M 2 □ F Director Aug. 1, 1927 219-14-2853 Usuel Residence of Dece permit. Peges 1 end 2 should be filed within 72 hours after deeth with the Meryland Depertment of Heelth end Mentel Hygiene. Depertment of Heem 27 ie marked other than "naturel", or heme 23a or 28e-f ehow eny Injury or other treumetic event, the Medical Examinar must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director MDWicomico Salisbury 10c. Citizen of What Country? 10e Street and Number 10f. Zip Code by Funeral 1301 Sprull Drive 21804 USA 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, White, etc. NGYes 2 No 1 ☐ Never Married 2 ☐ Married Baitlmore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates 1946 - 47 Pennsylvania Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Piano Tuning/Rebuilding <u>self-employed</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) å George Edward Dashiell, Sr. Mary Catherine Stanley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bronte' Dashiell/son 1301 Sprull Drive - Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/11/09 Hurlock, Maryland Eastern Shore V.A. Cem. 22. Name and Address of Facility 1213 Jersey Road - Salis. MD 21. Signature Funeral Service Licenses arreia JOLLEY MEMORIAL CHAPEL 23a. Part1. Enter the disease, or complications that caused the dea shock, or heart tailure. List only one causet in each line. h. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical 2419r Asovo Examiner Due to (or as a consequence of): by Physician/Medical Examiner 3 Months Dementia or Attending Physician: The lew requires that the deeth certificate be asscuted **burial-transit** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): and physician is the burial Division of VItal Records, P.O. Box 68760, Due to (or as a consequence of) USB BS after deeth. I Director: After this certificate has been signed by the attending I Id in by the funeral director, page 2 should be detached for use as 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to 24a. Was an eutopsy performed? Completed completion of cause of death? 214No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours att To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number mhe Nahr August 5/5 2009 Dc51359

State Registrar

31. Date filed (Month, Day, Year) AUG 11 2009

DK-USHA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NATESAN

32. Registrar's Signature of Sparks

ST, SALISBURY

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month 9:15 P.M Physician 2009 N. DRAGNICH ALEY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** Prince Georges Collington Health Center Mitchellville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 1√2 M 2□ F Yrs. 97 Feb. 22,1912 Washington Director 531-14-8189 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a. State 10b. County 10c. City. Town or Location ral', or Itema 23a or 28a-f show Examiner must be notified at 1 XYes 2 ☐ No Mitchellville MD Prince Georges Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 20721 U.S.A. 10450 Lottsford Road Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
And if item 27 is marked other then "natural, or itee
any or other traumatic event, ITE Maclicia Establia 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: White by 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Education 5+ Professor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Knezevich Stella Dragnich Nick D. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10128 Alix Lombardo/Daughter 1172 Park Avenue, New York, NY 20b. Place of Disposition (Name of cometery, crematory or other place)
Geo. Wash. University
Medical Center 20c. Location - City or Town, State 20a. Method of Disposition Aug. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. Ceo. Was Medical Washington, D.C. 4 ☐Donation 5 ☐ Other (Specify) 2009 22. Name and Address of Facility Columbia Mortuary Services, P.A. 2 Signature of Funeral Service Licenses 9013 Annapolis Rd., Lanham, MD 20706 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician nermouna /Medical Que to (or as a consequence of Examiner acilove 10 Sequentially list roodlions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit The law requires that the death certificate be executed wephilopa onsequence Due to (or as a P.O. Box 68760, physician o Vo hour Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, þ 99 3 Probably 4 ☑Unknown aulle 2 🗀 No Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 2 🗆 No certificate K New School.c 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Vursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA P 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: After 5 Pending investigation Injury Hospital or Attending 1 Natural 1 □ Yes 2 □ No after death. 2 Accident the 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one and manner stated. within 2 29c. License number 29b. Signature and title of certifi D042049 August Name and address of person who completed cause of death (Item 23a) (Type, Print) upper Mariboro. hampaloup Main 6 31. Date filed (Month, State AUG 1 3 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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/Medio		4a. Facility Name (If not insti		treet and numb	e <i>r</i>)		4b. City, Town, or	Location of Deat			ty of Death	77.10 4
LAGIIIII	iei	Union Hospital					Elkton			Cec	il	
uneral		5. Social Security Number	6. Sex		Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bir (Month, Da	th v Year)	9. Birthpla Countr	ce (State or Fore
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ns 2	era	11. Marital Status	1	12. Was Decede	nt Ever in U	.S. 13. \	Was Decedent of H	ispanic Origin? (S	pecify Yes or No		ace - America	n Indian,
"natural", or items 23a or 28a-f show edical Extraitment be profified at	by Funeral	1 Never Married 2 3 Widowed 4 Divo		Armed Force 1 Tyes 2 If Yes, Give Year or Date	VNo		if Yes, specify Cuba 1 □ Yes 2 ☑ No	n, Mexican, Puer	o Rican, etc.)	Spec	lack, White, etc cify: Whi	
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is marked o	To Be	Fred E. Fish						Caroline	Lewis			
item 27 is marked		19a. Informant's Name/Rela	tionship (Typ	oe. Print)		19b. Mailir	ng Address (Street	and Number or R	ural Route Numb	er, City or Tov	n, State, Zip C	Code)
27 i		Emily Ackerman	n/Sister			8532	Manchester	Rd., Silver	Spring, MD	20901		
r et		20a. Method of Disposition		16	20b. F	Place of Dispo	sition (Name of natory or other place	e)	Date	20c. Locatio	n - City or Tow	n, State
ant: If its		1 ☑ Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Oth		emoval from Sta	ite	Elkton Cen			zust 13, 2009	Elkt	on, MD	
Important: any injury once.		21. Signature of Fund 1	License	90			2. Name and Addres					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-05896 State of Maryland / Department of Health and Mental Hygiene Kevin M. Fluker 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Year 2157 hrs July 27, 2009 Medical Examiner Kevin M. Fluker 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Glen Burnie Route 2 Southbound at Ordnance Road 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director own qinia 12 1988 226-57-6314 20 2 F Aua 1 X M Usual Residence of Decedent 10d. Inside City Limits IOc. City, Town or Location 10b. County Yes 2 X No Anne Arundel Glen Burnie 28a-f show Maryland or items 23a or 28a-f show must be notified at once. death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 121 Warwickshier Lane Apt K 21061 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 X No Yes Black If Yes. Give Year Yes 2 X No specify: Specify: Widowed Divorced Pages 1 and 2 should be filed within 72 hours after neur of Health and Mental Hygiens and ant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner. þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Anne Arundel Co. MD 21215-0036 and 2 should be filed within 72 ho rath and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12th 3yrs Stocker College Bookstore 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vernon D. Fluker Sr Barbara Flowers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Nig Code) 2 1 0 6 1 19a. Informant's Name/Relationship (Type, Print) ဥ Barbara Fluker-Edwards(Mother) 121 Warwickshier Lane Apt K Glen Burnie 20c. Location - City or Town, State Baltimore, I permit Pages I and Department of Healt Important: If item injury or other trau 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State 8-3-09 Baltimore, Md. Metro Crematory Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 2Willime and everse FellitySons Mortuary, P.A. 821 West St. Annapolis, Md. Part I. There the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart MO6483 Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical a. Multiple Injuries Immediate Cause (Final disease -xaminei or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDED ending physician use as the burial -UNPENDED Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Ectopic pregnancy Live hirth Fetal death past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown Unknown detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I of Vital Records, P.O. þ Yes 2 V No 3 Probably 4 Unknown Completed 24a. Was ar 24b. Were autopsy findings available autopsy prior to completion of cause of has death? performed? 1 ✓ Yes 2 1 🗸 Yes 26.Place of Death (Check only one Hospital or Attending Physician: 25. Was case referred to medical Be examiner? Residence 6 V Other: Scene Inpatient ER/Outpatient 3 DOA Nursing Home 5 this 1 V Yes 28a. Date of Injury 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Certification: Pedestrian struck by auto Jul 27, 2009 Division 1 Natural Yes 2 ✔ No Pending 24 hours after death. Funeral Director; the 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) Route 2 Southbound at Ordnance Road, Glen Burnie, M (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the 1

Death

29d. Date signed (Month, Day, Year)

July 28, 2009

DHMH 17 Rev 1/2001 **OCME 2006**

31. Date filed (Month, Day, Year, State Registrar

one)

29b. Signature and title of certifier

Donna M. Vincenti, MD

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

and manner stated

1000

Assistant Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Everninar must be notified at Baltimore, Maryland 21215-0036

Physician /Medical

Physician /Medical

Examiner

Be Completed by Funeral Director

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Funeral Director

Examiner Division of Vital Records, P.O. Box 68760,

State Registrar				Cer	tificate of l	Death	_	g. No.	200	0.7	20
	ne (First, Middle, Last)	Press					2. Date of Death Month	Day	Year	3. Time of	
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,	If not institution, give str	·			4b. City, Town, or Waldo	Location of Death			ty of Death		
Fenwio	ck Nursing		e (In yrs. last biri	thdair	Waldo If Under 1 Year	Y-I If Under 24 Hrs.	8. Date of Birth	Char	9. Birthp	place (State	or Foreir
•	1□ 1	M 21∏ F 7. Age	, ,	rthday) _ Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,) 8/3/19	^{Yea} r) 15	Cour		
224 26 sual Residence o) /33/										
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Md	Charles	;		Wá	aldorf		. 1				2 🗌 No
De. Street and Nu					10f. Zip Code			g. Citizen of	What Coul	ntry?	
3605 M	loses Way		-	_	20602			JSA			
1. Marital Status		2. Was Decedent E Armed Forces?		13. W	Vas Decedent of h Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- Rican, etc.)		ace - Americ ack, White,		
	ried 2 Married	1 □Yes 2 🔀 N If Yes, Give			□Yes 21 No	Specify:		Speci	ify:		
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	(First, Middle, Last)					18. Mother's Nam	ne (First, Middle, Ma	uiden Surna	ıme)		
Jos	ephus Bar	low				Pearl	English				
	lame/Relationship (Type			,	•	and Number or Ru	ral Route Number,				
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0a. Method of Dis	sposition		cemeter	rv. crem	sition (Name of natory or other place	ce) !		Oc. Location	,		
	☐ Cremation 3 ☐ Ren 5 ☐ Other (Specify)	moval from State	Fairm	oun	t Cemet	ery 8/1	4/09 B	edfo:	rd,	Virgi	nia
	uneral Service Licensee	R .		_ 22.	. Name and Addre	ss of Facility Br	riscoe-T	onic	Fune	eral	Home
· Kin	rlienda 11	JUDE M	fance	22	94 Old	Washing	ton Rd.	Wal	dorf,	, Md	2060
23a. Part 1. Enter 1	the disease, or implica art failure. List only one	tions that caused	the death. Do i	not ente	er the mode of dyir	ng, such as cardiac	or respiratory arres	st,	2	Approxima Interval Be	tween
mmediate Cause	(Final	Jacob on each li	mad.	11	Dul	mani	1111 1	7111	Veral	Onset and	
disease or condition resulting in death)	on	Due to (or as	a runse wence,	gh:	fuce	1 -	my 1	ul	MI	- WIL	y
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esulting in death)		Due to (or as	a consequence	of):							
	d.										
								I			
E EENANI E	it pregnant	c. If yes, outcome	2 Fetal death		Ectopic pregnanc	у			Date of deliv	,	Year
F FEMALE: 23b. Was deceden	months?				Other (specify)				Month	Day	Year
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

BB6 State

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)

29b. Signature and title of certifier

30. Name and address of person

Year)

31. Date filed (Month, Day,

Registrar

DHMH 17 Rev 1/2001

32.

who completed cause of wath (Item 23a) (Type, Print)

Degistrar's Signature

121

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I cal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date/signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Deceden Ns Name (First, Middle, Last) 3. Time of Death Day Year **Physician** Vionth 20PM GARE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number Examiner TRUNDOL 0m05 NNAPOZIS If Under 24 Hrs. Date of Birth (Month, Day, Year) 6/10/1918 If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min Maryland Months Days Hours 1 □ M 2 🕱 F 212-14-3471 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Experiment until be rectified at once. 28a-f show Maryland Anne Arundel Annapolis 1 ☐ Yes 2 🕱 No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3023 Arundel on the Bay Road 21403 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 📆 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☑ No Specify: White þ 3 ☑ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary <u>Insurance</u> Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Branzell Nina Popham ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Carol Vodak - Friend 807 Severn Avenue, Annapolis, MD 21403 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State St. Mary's Cemetery 8/5/2009 Annapolis, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home, Inc 21. Signature of Funeral Service License 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** YOCARDIAL TIE disease or condition resulting in death) MINUW /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a collsequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregrant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 🔲 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe NO 2 No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 15515100 Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Mann f Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print

DHMH 17 Rev 1/2001

State Registrar

The law requires that the death certificate be executed Box 68760 P.0. þ has certificate After this death.

death with the Maryland

Baltimore, Maryland 21215-0036

the attending plane of the the Hospital or Attending Physician:

Division of Vital Records. Certification: If Director: And in by the ft Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal and manner stated. 29b. Signature and title of certifie

29d. Date signed (Month, Day, Year)

30. Name and address of person completed cause of death (Item 23a) (Type, Print)

ivingston Rd., Suite 308 Amin 11701

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 200 9 12:32 A M Ruby B. Van Horn August 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Westminster Dove House If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nin. | Aug • 22,1924 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 407-22-0178 1 □ M 2 🛛 F 84 Yrs. Kentucky Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Baltimore Maryland 1 XYes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21211 613 West 33rd Street 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) 2 \(\text{N} \) No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married white 1 □Yes 2X No Specify. 3 X Widowed 4 ☐ Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, PO NOT use retired)
facility house care Elementary/Secondary (0-12) College (1-4or 5+) hospital 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nora Triplett James Freeline Woods 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Hampstead, Maryland 21074 Clay Allen Van Horn - son 2541 Bert Fowler Road 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Aug. 1. 2009 1 N Burial 2 Cremation 3 Removal from State Hampstead, Maryland Hampstead Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Eline Funeral Home 934 South Main Street HAmpstead, Maryland 21074 M01072 Approximate Interval Between Onset and Death 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dving such as cardiac or respiratory arrest shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Day 5 Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 2 **N**0 2 **N**o 1 ☐Yes 1 ☐ Yes 26. Place of Death (Check only one) 6 Other (Specify) DOVE HOOV Other: 4 Nursing Home 5 Residence 2 **□**No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred

Examiner spital or Attending Physician: The law requires that the death certificate be executed outs after death, rest in this certificate has been signed by the attending physician and rilled in by the funeral director, page 2 should be detached for use as the buriel-transit signed by the attending physician and I be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Physician

Examiner

Funeral

Director

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Director

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Completed

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th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-1 show traumatic event, the Madical Extrainer must be retified at

permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau

Physician

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

the Maryland

/Medical

/Medical Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ Completed 25. Was case referred to medical examiner? Be 1 ☐ Yes Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 5 ☐ Pending investigation 1 Tyes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check one) and manner stated 29b. Signa e and title of certifie

To the Hospital of within 24 hours a To the Funeral Completely filled in the Funeral Completely filled in the second seco

Hospital

State Registrar

death (Item 23a) (Type, Print)

Registrar's Signature

		For State Registrar	State of N	Marylan		artmen rtificat			and M		gieņe Reg. No.	009	27385		
		Decedent's Name (First, Middle, Last	")							2. Date of Dea	ath	Vone	3. Time of Death		
Physicia		Robert Earl Ha	rgett							Month August	15.	2009	4:26 A. M		
/Medic Examin	_	4a. Facility Name (If not institution, give	street and number	er)		4b. City,	Town, or	Location o	of Death			ounty of Death			
		3214 Western Pike	2			На	ncoc	k			Wa	shingt			
Funeral		Social Security Number 6. Se		Age (In yrs.	ast birthday)	If Under Months	1 Year Days	If Under:	24 Hrs. Min.	8. Date of Birt (Month, Da	h y, Yea <i>r</i>)	9. Birth	place (State or Foreign intry)		
Director		217-52-6800	ДМ 2□F		58 Yrs.	Nontrio	Dayo			Nov.21	,1950	MD			
p .		Usual Residence of Decedent 10a. State 10b. County		10c Cib	y, Town or Lo	cation							10d. Inside City Limits		
anyla	_					cation							1 ☐ Yes 2 ☑ No		
8e-f	5	MD Washingt	on	па	ncock	1					10- Cities	en of What Cou			
be filed within 72 hours after death with the Maryland tall Hygiene. ad other than "natural", or Items 23e or 28e-f show event, the Medical Examinar must be notified at	by Funeral Director	10e. Street and Number				10f. Zip						SA	and y :		
s 23e	ra	3214 Western Pike		-4 Francis III	D 142		1750	i- Ori	-:-2 (5-	noite Van as No		JA I. Race - Amer	ican Indian		
er de	une	11. Marital Status	12. Was Decede Amed Force	s?	3. 13.	was Deced If Yes, spec	ent of Hi	n, Mexican	, Puerto	ecify Yes or No Rican, etc.)		Black, White			
s aft	Ϋ́	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 { If Yes, Give 4 Year or Date:	Λ		1 ☐ Yes	2 ₹ No	Specify:			° s	Specify: W	hite		
hour	Pd t	15. Decedent's Ed			16a. Dece	dent's Usua	al Occupa	ntion			16b. Kind	d of Business/li			
d 2 should be filed within 72 hours aft that and Mental Hygiene. Its marked other than "natural", or treumatic event, the Medical Exam.	Completed	(Specify only highest grad	le completed)		(Give	kind of wo	rk done d	luring most	t of work	ing			•		
with ene. thar	E	Elementary/Secondary (0-12)	College (1-4d	or 5+)	Carpe	enter					Cons	structi	on		
should be filed within the Menial Hygiene. marked other than matic event, the Menial Hygiene.	BeC	17. Father's Name (First, Middle, Last)	,		-			18. Mothe	r's Name	(First, Middle,	Maiden S	iumame)			
ld be ental ked o	10 B	Charles E. Harg	ett					Do	lore	s Dorni	ng				
s 1 and 2 should I f Health and Men item 27 Is marke other treumatic		19a. Informant's Name/Relationship (7	ype, Print)		19b. Maili	ng Address	(Street a	ind Numbe	r or Run	Al Route Numbe	er, City or	Town, State, Z	ip Code)		
nd 2 lith a 27 is r tre		Hope S. Hargett/V	Vife		3214	West	ern	Pike	Han	cock,MD	2175	0			
is 1 and 3 of Health item 27 other tra		20a. Method of Disposition		20b. P	lace of Dispo emetery, crei	sition (Nar	ne of	ا (ه		Date	20c. Loca	ation - City or 1	Fown, State		
Page ent o nt: If		1 ☐ Burial 2 X Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify	Removal from Sta)						8/18	/2009	Smith	sburg.	MD		
permit. Pages Department of I Importent: If its any injury or of		21. Signature of Funeral Service Licen		moor	260 2	2. Name an	d Addres	s of Facilit	У		st Ma	in Str	eet		
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ysician: The law requires t is certificate has been signe director, page 2 should be c	Be (25. Was case referred to medical examiner?							of Deat	h (Check only o	ne)				
Q 20. X	2	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpa	atient 2 🗆	ER/Outpatier	nt 3□ DC	OA Othe	er: 4□Nu	rsing Ho	me 52 esi	dence 6	□Other (Spec	cify)		
ding Ph h. After th funeral		27. Manner of Death Natural 5 ☐ Pending	28a. Date of I	njury Day Year)	28b. Time o Injury		8c. Injury Work	·?		28d. Describe	how injury	occurred			
ttendi death. ctor: A / the fu	ati	2 Accident investigation				М	10,	Yes 2□	No						
r Att	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	280. Place of	Injury - At he etc. (Specif	ome, farm, st y)	reet, factory	, office			28f. Location (City or To		Number or Ru	ral Route Number,		
To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		29a. Certifier 1 Certifying Physics (Check only 2 Medical Exam	vsician: To the be	est of my kno	wledge, deat	h occurred	at the tim	ne, date an	d place,	and due to the	cause(s) a	and manner as	stated.		
thin 24 the H	Medical	one) 29b. Signature/and title of certifier	and manner	stated.	1		. License					signed (Month			
± ≥ ± 0	0	30, Nam. and address of person who of	completed cause of	of death (Item	n 23a) (Type,	Print)	D 4	+64 AL	7; C	3 , T. H	Aug	ust	17, 2009 in, MD 2174		
Sta	te	31. Date filed (Month, Day, Year)		istrar's Signa	ure								,		
Registra	ar	AUG 26 g	009	neur	A. 1	BANG									

Physician

/Medical

Examiner

Funeral

Director

1. Decedent's Name (First, Middle, Last)

Holy Cross Hospital

5. Social Security Number

577-15-2696 Usual Residence of Decedent

Jamal Timothy Jackson-Thorpe

6. Sex 1 ፟ M 2 ☐ F

7. Age (In yrs. last birthday)

21

Yrs.

4a. Facility Name (If not institution, give street and number)

	ylanc now		10a. State	10b. County		10c. City,	, Town or Loca	ation						10d. Inside City Limits
	Mar a-f sk	Ş	MD	Prince G	eorge's	For	t Wash:	ingto	n					1X Yes 2 □ No
	r 28g	ire	10e. Street and Nur					10f. Zip (10g. Ci	tizen of What Co	ountry?
	h with	alD	10008 E	dgewater	Terrace				20	744			USA	
	ems ems	Funeral Director	11. Marital Status		12. Was Decedent E	ver in U.S	3. 13. W	as Decede Yes, specif	ent of Hisp	anic Origin? (Specify Yes or Norto Rican, etc.)	10-	14. Race - Ame Black, Whit	
36	or it	Y.		ied 2 Married	Armed Forces? 1 ☐ Yes 2 X N If Yes, Give	lo	1	JYes 2	77	Specify:	rio i nodin, otor,		Specify: B	
8	72 hours after death with the Maryland natural", or Items 23a or 28a-f show dical Evaminar must be notified at	d by	3 Widowed		Year or Dates:		10 0		_			T total		
215-0036	n 72 "nat	Completed		15. Decedent's Ed cify only highest gra	ide completed)		16a. Decede (Give k		done dun	on ing most of w	orking	16b. K	(ind of Business	rindustry
212	within piene. r than "	E	Elementary/Seco	ndary (0-12)	College (1-4or 5-	+)	Custo			re		Reta	ail	
	filed value of the cother incent, the	BeC	17. Father's Name	(First, Middle, Last)				cr_b			ame (First, Midd	1		
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygiene. If item 27 is marked other than "naturat", or items 23a or 28a-f show or other traumatic event, if at Medical Examinat must be notified at	To E	Timothy	Thorpe						Tina 3	Jackson			
ary	should and Mer is marke	-		ame/Relationship (-	19b. Mailing	Address (Street and	l Number or i	Rural Route Nun	ber, City	or Town, State,	Zip Code)
Σ	is 1 and 2 and Health a item 27 is other trau		Timothy '	Thorpe/Fa	ther		10008	Edge	watei	r Ter.,	Ft. Wa	sh.,	MD 207	44
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		20a. Method of Disp		Removal from State	20b. Pla	ace of Disposi metery, crema	tion (Name itory or oth	e of ner place)		Date	20c. L	ocation - City or	Town, State
Ë	Pag ment ant:			5 ☐ Other (Specify		Res	surrect				13/2009		nton, M	
3alt	permit Depart Import any Inj once.		21. Signature of Fu	ineral Service Lice	see		22.	Name and	Address	of Facility S	trickla	ıd Fu	neral S	ervices
	교교 등 등 이		Touc	W. A	recliand	_					., Camp		ngs, MD	
			shock, or hea	rt failure. List only	plications that caused one cause on each lin	the death. e.	. Do not enter	the mode	of dying,	such as cardi	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
The same	Physician /Medical		Immediate Cause disease or condition resulting in death)	(Final n	a. Septic									
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	outed id ansit	Ē	cause. Enter Unde Cause (Disease or that initiated events	rlying injury	c. Possible Pneumonia									
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9 x		HIV (Presumptive) FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 5 Other (specify) 9 Unknown 9 Unknown 9 Unknown 23d. Date 23d. Da												
Вох	eath c attend for us	ian/	23b. Was decedent in the past 12	months?	1 ☐ Live birth :	2 Fetal	death 3 🗌	Ectopic pre				*	23d. Date of de Month	livery Day Year
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σ.	s that ned b deta	by Pt	Part II. Other signif	icant conditions o	ontributing to death bu	it not resul	ting in the unc	lerlying cau	use given i	in Part I.	23e. Did	l tobacco	use contribute t	o the cause of death?
tal Records,	w requires been sign should be	q pe									. 10	Yes 2	□ No 3□ P	robably 4 X Unknown
900	law re as bee 2 sho	Completed									24a. Wa		24b. Were a	utopsy findings available
Ä	an: The lantificate hator, page ?	ĕ									per	opsy formed? 2 XNo	death?	completion of cause of s 2 □ No
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of Vi	Physicia r this cert ral direct	၉	1 Yes 2 🛣				ER/Outpatient		Other:	4 🗆 Nursing	Home 5 ☐ Re			ecify)
nc	or Attending Physician: after death. Director: After this certification by the funeral director; in	Certification:	27. Manner of Death 1 XNatural	5 Pending	28a. Date of Injur (Month, Day	y (, Year)	28b. Time of Injury	M 28	c. Injury at Work?		28d. Describ	e how inju	ry occurred	
Division	Vttend death ctor: y the	licat	2 ☐ Accident 3 ☐ Suicide	investigation 6 ☐ Could not be		rv - At hon	ne farm stree			s 2 No	28f Location	(Stroot a	nd Number or B	ural Route Number,
Ξ	after after Dire	erti	4 Homicide	determined	building, etc	. (Specify))	, idotory,	011100		City or T	wn, State	e)	arar route rumber,
	To the Hospital or Attending is within 24 hours after death. To the Funeral Director: After completely filled in by the funeral		29a. Certifier	1 Certifying Ph	ysician: To the best o	of my know	vledge, death	occurred a	t the time,	date and pla	ce, and due to the	e cause(s	s) and manner a	as stated.
	he Ho in 24 he Fu pletel	Medical	(Check only one)	2 Medical Exan	niner: On the basis of and manner sta	examinati ted.	ion and/or inve	estigation, i	in my opin	ion, death oc	curred at the tim	e, date an	d place, and du	e to the cause(s)
_	Vith with Con	Σ	29b. Signature and	title of certifier					License n			29d. Da	ate signed (Mon	th, Day, Year)
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1	, 1				completed cause of de									
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Ę	Sta Registr		AUG 1 3		wa V.	far	مدي							
DHI	MH 17 Rev 1/2	001			•								<u> </u>	
							ORIGI	NAL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min.

Silver Spring

2. Date of Death Month

8. Date of Birth (Month, Day, Year)

08/26/1987

August

3. Time of Death

11:58A.

Birthplace (State or Foreign Country)

DC

Year

2009

Montgomery

4c. County of Death

06,

■ Baltimore. Maryland 21215-0036

			For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of H rtificate of E			giene Reg. No. 🦈 🍵	0.0	17 mm 17 C	2.7
			Decedent's Name (First, Middle, La	st)				2. Date of De	ath &		3. Time of Deat	th
	Physici	an	Alda L.	Keene				Month	Day 2.0	Year 009	9:05 A	A _M
-	/Medic		4a. Facility Name (If not institution, giv			4b. City, Town, or	Location of Death	August		y of Death	9:05 F	1
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كالمسيين			1032 Dockser Dri				nsville	1		Aruno		
н	Funeral		5. Social Security Number 6. S	Sex 7.Age I□M 252TF	(In yrs. last birthday)	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da	in y, Year)	Cour		•
	Director		5/9-05-8635		92 Yrs.			May 23,	1917	Wash:	ington, I) <u>.C</u>
	pu 🖈		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	eastion				1	0d. Inside City Lir	mite
	arylan show	_			Toc. City, Town of Le					Ι.	1 □ Yes 2√2	
	Ba-f	Sch	MD Anne Ar	undel		Crow	nsville					140
	th th	ië	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cour	ntry?	
	h wi	<u>a</u>	1032 Dockser Dri	ve		2103	32			Ţ	JSA	
	deat	Funeral Director	11. Marital Status	12. Was Decedent E	ver in U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp	ecify Yes or No	- 14. Ra	ce - Americ		
(0	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Modeol Everrine must be notified at		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2X N	0			Hican, etc.)	Bla	ack, White,	etc.	
ဇ္ထ	urs a	ρ	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1∐Yes 2∭XNo	Specify:		Speci	fy:	White	
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Maryland	2 sh n and is n		19a. Informant's Name/Relationship	• •		ng Address (Street a				n, State, Zip	Code)	
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Sec	of H of H roth		20a. Method of Disposition		20b. Place of Dispo cemetery, crei	sition (Name of matory or other place	9)	Date	20c. Location	- City or To	own, State	
Ĕ	Page nent nt: If		1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specia		Baldwin M			/2009	Millers	sville	.Marylar	nd
Baltimore,	artm orta inju		21. Signature of Funeral Service Lice	· · · · · · · · · · · · · · · · · · ·		2. Name and Addres	o of English				, ,	
<u>~</u>	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra <u>once</u> .		OK P. 2	2	6	512 NW Cra		Beall Fu , Bowie,				
			23a. Part1. Enter the disease, or con- shock, or heart failure. List only	plications that caused	the death. Do not en	ter the mode of dying	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between	1
18	Physician		Immediate Cause (Final	1 41-1		n do	ment	es			Onset and Death	h
Br.	/Medical		disease or condition resulting in death)	a. Duo to for any	a consequence of):	GEN.	1 WIII	6.1			gecia	
and i	Examiner			Due to (or as a	consequence or,					4		
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	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a	a consequence of):							
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87	cate ohysi the t	dical	•	d								
9	leath certific attending p	Mec	IF FEMALE:									
Вох	th ce rendi	an/I	23b. Was decedent pregnant	23c. If yes, outcome		☐ Ectopic pregnancy	,			ate of deliv	*	
Ш.	dea e att	ici	in the past 12 months? 1 □ Yes 2 □ No	4 Pregnant at		Other (specify)			l N	lonth	Day Year	
P.0	at the de I by the stached	Physician/Me	9 ☐ Unknown	9 Unknown								
	tha ned det		Part II. Other significant conditions	contributing to death bu	t not resulting in the u	nderlying cause give	n in Part I.	23e. Did t	obacco use co	ntribute to t	he cause of death	?
g	uires n sign Id be	d by						1 🗆 '	Yes 2 □ No	3 ☐ Prol	bably 4 nkn	own
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ě	e law	ldu						24a. Was autoj	osy /	prior to co	ppsy findings avail mpletion of cause	able of
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-	di is	To	1 Yes 2. No	Hospital: 1 ☐ Inpatie	nt 2 ER/Outpatie	nt 3 ☐ DOA Othe	er: 4 🗆 Nursing H	ome 5 TResi	dence 6 □ O	ther (Specia	fy)	
o c	g Pr	Ë	27. Manner of Death	28a. Date of Injui		f 28c. Injury Work	at	28d. Describe	how injury occu	rred		
Division	Attending F r death. ector: After by the funera	iţ.	1 Natural 5 Pending 2 Accident investigatio		(, Year) Injury		r ∕es 2 □No					
S	Attend death. ctor: / y the fi	fica	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of Inju	ry - At home, farm, str . (Specify)	eet, factory, office		28f. Location (Street and Nun	ber or Rura	al Route Number,	
<u> </u>	or Joine Dire	Certification:	4 Homicide	building, etc	. (Specify)			City or To				
	Hospital or 24 hours afte Funeral Dir tely filled in I		29a. Certifier 1 Certifying Pi	hysician: To the best of	of my knowledge deat	h occurred at the tim	ne date and place	and due to the	calleg(e) and	manner as a	stated	
	Hos 24 hc Fun stely	edical	(Check only 2 Medical Examone)	miner: On the basis of	examination and/or in	vestigation, in my or	pinion, death occu	rred at the time,	date and place	, and due t	o the cause(s)	
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Mec	29b Signature and title of certifier	and manner sta	iou.	29c. License	numher	Т	29d. Date sign	ed (Month	Day Year)	
	Nuit Son	-	29b Shighature and title of certifier	1 1	/ 4	290. License	D 607	2 2	O -	2 -	7000	
				/	1	10	1001	0/0	0	0	XUUL	
<u>.</u>	110		30 Name and address of person wife	completed cause of de	eath (Item 23a) (Type,	Print) /	. 1		1.11	-	-11 8	LIC
4	410		Knniter K.	redina	25860	Veter	ans H	WU/	1.40.	SVI	110 M	0
Ď	Sta	ite	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	1		1				
	Registr	ar	AUG 04	2009 Dens	ir's Signature	ance						
- CLU	MH 17 Rev 1/2	001					-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month Thomas Neal Kemp 2009 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Good Samaritan Hospital 5 Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 6 Sex Months Days Hours Min. 1 DKM 2 DF 43 219-58-7046 11/2/1965 MD Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1X Yes 2 No Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code USA 21234 2831 Rosalie Ave. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑Yes 2 ☐ No
If Yes, Give 1987— Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married If Yes, Give 1987-93 Year or Dates: 1 ☐ Yes 2 ☐ No white Specify Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) H & S Bakery deliveryman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carol J. Carter Vincent T. Kemp 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2926 Warehime Road, Manchester, Md. 21102 Carol J. Kemp, mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 8/10/09 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Owings Mills, 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee M00741 Eline Funeral Home 934 S. Main St., Hampstead, Md. Man 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on unch line.

Immediate Cause (Final Myocardia disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, bearing to intrinsulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or selection of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) ☐Yes 2 ☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 Avatural 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

or Attending Physician: The law requires that the death certificate be executed and the burial-P.O. Box 68760, physician use as t for detached the Division of Vital Records, should be After this certificate has funeral director, page 2 s death. after death the completely filled in by Hospital 24 hours

Physician

/Medical

Examiner

Funeral

Director

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Medical Certification: To

29a, Certifier

29b. Signature and title of certifie

death with the Maryland

To the within 2 WIL STIVA

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -

and manner stated

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

158570

Good Simon ton Hospiells lerrance L. B 32. Redistrar's Signature 31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Khadijah Medinah Khan Certificate of Death 1- For State Registrar Time of Death 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day August 16, 2009 1603 hrs Medical Examine Khadijah Medinah Khan 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Annapolis Anne Arundel Medical Center If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number Country District **Funeral** Months Days Hours 6/20/1952 57 Director 577-72-4281 1 M 2 XF Columbia Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 'n 1 Yes 2 X No Upper Marlboro 28a-f show Prince Georges Md. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20772 U.S.A. 5700 Old Crain Hwy. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. traumatic event, the Medical Examiner must be Armed Forces' 1 Never Married 2 XMarried Yes 5 Specify: Black If Yes, Give Year Yes 2 X No specify: Divorced Widowed 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed itimore, MD 21215-0036
The Pages I and 2 should be filed within 72 harmon of Health and Mental Hygienerstant: If item 27 is marked other than "that or other traumatic event. It is an expense in the standard of the standard other than "that or other traumatic event." Flementary/Secondary (0-12) College (1-4 or 5+) Homemaker Home 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dollv Tvler Henry Harley Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20904 19a, informant's Name/Relationship (Type, Print) 11789 Carriage House Dr. Silver Spring, Md. Anwar Khan 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition Baltimore, crematory or other place) Burial 2 Cremation 3 Removal from State Laurel, Md. Maryland National 8/19/09 Donation 5 Other Specify 22. Name and Address of Facility Universal Mortuary nature of Funeral Service Licensee Washington, DC 2001 St., N.W. Kennedy 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Physician Between Onset and failure. List only one cause on each line Death Medical a. Hyperthermia Immediate Cause (Final disease kaminei or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed 23a,27,28a-f,perME, g895 9/15/09 TT Physician/Medical tending physician a X UNPENDED AMENDED Box 68760, 23d Date of delivery IF FEMALE: 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the Month Dav Year 3 Ectopic pregnancy Live birth Fetal death past 12 months' Pregnant at time of death Other (Specify) 5 Yes 2 No 9 ✔ Unknown а Unknown the ned by the detached f 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o Yes 2 No 3 Probably 4 V Unknown ģ Records, P. Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? has nerformed? 1 🗸 Yes ✓ Yes 2 certificate 26 Place of Death (Check only one) 25. Was case referred to medical the Hospital or Attending Physician: hin 24 hours after death. Be Division of Vital Other₄ Hospital: 1 Nursing Home 5 Residence 6 Other: DOA Inpatient 2 V ER/Outpatient 3 this ဥ 1 V Yes 28d. Describe how injury occurred exposed to high 28c. Injury at Work? 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury After 27. Manner of Death Certification: Yes 2 X No Natural Director: Pending environmental temperatures Fd 3:28 pm Fd 8/16/09 2 XAccident Investigation 28f. Location (Street and Number of Rural Route Number, City or Town, State) Sandy Point State 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Sulcide within 24 hours at To the Funeral D completely filled i Annapolis, MD determined (Specify) State Park Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Wedical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier August 17, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ana Rubio MD. 32. Registrar's Signature 31 **Aug**le **2** Mnt **2009** ear) State

OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death KING-CARR AUGUST 2009 6, 4a. Facility Name (If not institution, give street and number) 4c. County of Death TIMONIUM STELLA MARIS HOSPICE HOUSE BALTIMORE If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☐ M 2 🗓 F 213-86-4713 11/17/1956 Drewville, VA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Maryland Charles Waldorf 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2240 Sandalwood Drive 20601 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2√2 No Specify: Black 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary of Agriculture Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

Bessie Hines

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2240 Sandalwood Dr. Waldorf, Maryland 20601

29d. Date signed (Month, Day, Year)

TIMONIUM, MD 21093

filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f show permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if we Medical Evaminar must be notified at once. Baltimore, Maryland 21215-0036

AUGUST 6, 2009

Physician

/Medical

Examiner

Funeral

Director

TILDA

10a. State

12

20a Method of Disposition

Willie Powell Jr.

19a. Informant's Name/Relationship (Type. Print)

Paul King- Carr / Husband

Director

Funeral

ģ

Completed

Be

2

Physician /Medical Examiner

Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and neral Director: After this certificate has been signed by the attending filled in by the funeral director, page 2 should be detached for use as Certification: To

Division of Vital Records, P.O. Box 68760,

TILDA KING-CARR

1 Notice of Disposition 1 Not	lemoval from State	cemetery, cren	natory or oth	er place)	1	Date		ocation - Oity o	104411, 0	State
4 Donation 5 Other (Specify)		Heritage			8/14			dorf, N		land
21. Signature of Funeral Service License	y xely 0						uneral H estville			20747
23a. Part 1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the	e death. Do not ente	er the mode	of dying, such	as cardiac	or resp	oiratory arrest,		Inte	proximate rval Between
Immediate Cause (Final disease or condition resulting in death)	MELANOM	A							Ons	set and Death
The second of th	Due to (or as a c	onsequence of):								
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):									
that initiated events resulting in death) Last	Due to (or as a c	onsequence of):								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of 1 ☐ Live birth 2[4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal death 3	Ectopic pre Other (spec				_	23d. Date of do Month	elivery Day	Year
Part II. Other significant conditions con	tributing to death but r	not resulting in the un	iderlying cau	se given in Pa	rt I.	2	3e. Did tobacco	. /		use of death?
						ļ	4a. Was an autopsy performed? □Yes 2 X N	prior to death?	complet	indings available tion of cause of No
25. Was case referred to medical examiner?					ace of Dea	th (Che	eck only one)			
1 ☐ Yes 2 📉 No	ospital: 1 ☐ Inpatient	2 ER/Outpatien	t 3 🗆 DOA	Other: 4 🗆	Nursing H	lome 5	5 ☐ Residence	6 X Other (Sp	ecify)	HOSPICE
27. Manner of Death 1 ▼ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day, Y	(ear) 28b. Time of Injury	M 280	. Injury at Work? 1 □ Yes 2	□No	28d. E	Describe how inju	ry occurred		
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (- At home, farm, stre (Specify)	et, factory, c	ffice		28f. Lo	ocation (Street a lity or Town, Stat	nd Number or F e)	lural Rou	ute Number,
29a. Certifier 1 ☐ Certifying Phys (Check only 2 ☐ Medical Examir one) X Nurse Pract	sician: To the best of r ner: On the basis of ex itatomer stated	ny knowledge, death camination and/or inv d.	occurred at restigation, in	the time, date my opinion, o	and place death occur	e, and d	ue to the cause(the time, date ar	s) and manner and du	as stated ie to the	f. cause(s)
29b. Signature and title of certifier			29c. l	icense numbe	er		29d. Da	ate signed (Mor	ith. Dav.	Year)

Medical

State Registrar

JACKLE JONES,

2300 DULANEY VALLEY RD.

who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

			For 1 - State Registrar	State	of Marylar		artmeni rtificate			and M	ental Hygi	ene g. No.	09	27393
			1. Decedent's Name (First, Middl	e, Last)							2. Date of Death Month	Day	Year	3. Time of Death
	Physici /Medic		Eloise Libert	0								/2009		6:40 P M
	Examin		4a. Facility Name (If not institution	n, give street and n	umber)		4b. City,	Town, or	Location o	of Death		4c. Cour	nty of Death	
		rest.	Golden Living						tmins			(Carrol	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2XXXF	7. Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under a	Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp	place (State or Foreign htry)
4, 40	Director		232-28-9141 Usual Residence of Decedent		87		l				4/23/1	1922		KY
	land bw if		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						1	0d. Inside City Limits
	Mary	ţ	MD Ca	rroll		Westm	inste	r						1 ☐ Yes 2 X ☐No
	r 28e	Director	10e. Street and Number				10f. Zip	Code			10	g. Citizen o	of What Cour	ntry?
	13a o	O E	1234 Washingt	on Rd.				21	157				USA	
	deat	Funeral	11. Marital Status		cedent Ever in U	J.S. 13.	Was Deced	dent of Hi	spanic Orig	gin? (Spe	ecrfy Yes or No- Rican, etc.)		lace - Americ	
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8	within 72 hours after death with the Maryland ene. than "netural", or teme 23e or 28e-f e-how Le Medical Exercites must be notified at	d by	3 XWidowed 4 □ Divorced	Year or	Dates:								VVII.	
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an	ould be f Mental H wrked of	To Be	Harrison P. S	mith					Je	nny	Thompson	1		
Maryland	shou nd M mar	-	19a. Informant's Name/Relations	ship (Type, Print)		19b. Maili	ng Address	(Street a	and Numbe	er or Rura	al Route Number,	City or To	vn, State, Zip	Code)
	aith a 27 ls		Lynn Heise/Da	ughter		632	Oak '	Tree	Rd.,	Wes	tminster	, MD	21157	
ore,	of He of He of He of he r oth		20a. Method of Disposition	2 Domaval from	20b.	Place of Dispo cemetery, cre	osition (Nari matory or o	ne of ther plac	6)	ſ	Date	20c. Locatio	on - City or To	own, State
E	Page nent c int: if		1 Burial 2 ACremation 4 Donation 5 Other (5		II State	th Car			1	8/1	3/09	Winfi	ield, N	MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "natural", or Iteme 23a or 28e-f ehow any njury or other traumatic event, It a Madical Examinar meat the rolling and ODES.		21. Signature of Suneral Sovice	Licensee	01	2	Burri 1212	er-Q	i e Facilit 1d Li	Fune bert	ral Home	e & Cı Vinfie	emato	ry, P.A. D 21784
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	/Medical		disease or condition resulting in death)	a. Due t	o (or as a conse	quence of):			7000	(G	(()	0.0		
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	P #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due t	o (or as a conse	quence of):								
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ğ	w require been sig should b										1 □ Ye	s 2 No	3 ☐ Prol	bably 4 Linknown
Records,	awre ts bed 2 sho	Completed									24a. Was a		b. Were auto	opsy findings available ompletion of cause of
Ä	: The law cate has page 2:	Eo									perforr	ned?	death? 1 ☐ Yes	2 No
Vital	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?						26. Place	of Deat	h (Check only on	e)		
of V	S W D	2	1 ☐ Yes 2 ☐ No	-]Inpatient 2	ER/Outpatie			4-2-14/	ursing Ho	me 5 🗆 Reside			fy)
ū	fter free	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pendi		e of Injury onth, Day Year)	28b. Time of Injury		28c. Injun World			28d. Describe ho	w injury oc	curred	
sio	Attending r death. ector: After by the fune	cati	2 Accident invest	not be			М		Yes 2	No	28t, Location (St	root and Al	mhar as Dur	al Route Number,
Division	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification:		ninod 286. Pla	ce of Injury - At I Iding, etc. (Spec	nome, tarm, st	reet, factor	y, office			City or Town		inder or Aur	ar noute Number,
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State of	Maryland	/ Departm	ent of H	lealth and	d Mental	Hygiene

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	Physici	an REPNICE LEFTWICH								AUGUST	6, Day	009 Year	11:25 P M	
4	/Medic		4a. Facility Name (If not institution, give str		111110		4b. City, Town,	or Location				ounty of Deat	h	
	LXXIIII		CHERRY LANE NURSIN	IG HOME			LAUREL				PRI	NCE GE	ORGE	
	Funeral		Social Security Number 6. Sex	7. Ag	e (In yrs. la	ast birthday)	If Under 1 Year Months Day		er 24 Hrs. Min.	8. Date of Bir (Month, Da	th ly, Year)	Co	hplace (State or Foreign untry)	
55.	Director		244-40-3928	IVI ZIZIF	85	Yrs.				March	6, 19	24 WAS	HINGTON, DC	
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits	
	Maryl f sho	호	MD PRINCE GEO	RCF	T.ANT	OOVER							1 XYes 2 No	
	r 28a	Director	10e. Street and Number	KGL	LIZINI	OVER	10f. Zip Code				10g. Citize	en of What Co	untry?	
	h with		6211 OTIS STREET				2078	35				U.S.A.		
	ems :	Funeral	11. Marital Status	2. Was Decedent Armed Forces?	Ever in U.S	3. 13. V	Vas Decedent of f Yes, specify Co	Hispanic (Origin? (Spe	cify Yes or No Rican, etc.))- 14	 Race - Ame Black, White 		
36	amine		1 Never Married 2 Married	1 ☐ Yes 2 🛣 I If Yes, Give	No	1	I□Yes 2XDN	o Speci	fy:		8	Specify: BL	ACK	
Ö	hours tural	ed by	3 Vidowed 4 □ Divorced 15. Decedent's Education	Year or Dates:		16a Decer	lent's Usual Occ	unation			16h. Kind	d of Business/	Industry	
7	in 72 "na" (ledic	Completed	(Specify only highest grade	completed)		(Give	kind of work dor DO NOT use reti	e durina m	ost of workin	ng				
7	with jene. r thar the N	E O	Elementary/Secondary (0-12) 8th	College (1-4or 5)+)	HOU	SEKEEPII	NG			GO	VERNME	NT	
פַ	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or items 23a or 28a-f show arte event, the Medical Examiner must be notified at	BeC	17. Father's Name (First, Middle, Last)							(First, Middle	, Maiden S	Gurname)		
<u>Jar</u>	should band Ments s marked umatic e	To E	HOPE KING					ESS	IE MCG	FILL				
-	2 2 2 5		19a. Informant's Name/Relationship (Type	e. Print)		19b. Mailin	ig Address (Stre	et and Nun	nber or Rura	l Route Numb	er, City or	Town, State, 2	Zip Code)	
≥	l and lealth im 27 her ti		DIANE WILLIAMS/NIEC	CE	20h BI		OTIS ST			ER, MD		ation - City or	Town State	
Baltimore, Maryland 21215-0036	iges or ot		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Re	moval from State			sition <i>(Name of</i> natory or other p EMORIAL	lace)	8-14-			VER, M		
話	Ift. Partment infant njury	1	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee		nan		. Name and Add	Iress of Fac						
Ba	permit. Pages 1 and 2 sl Department of Health an Important; If item 27 Is r any injury or other traur		X X X X X X X X X X X X X X X X X X X	000			474 LAN							
			23a. Part1. Enter the disease or complic shock, or heart failure. List only one	ations that caused	the death	. Do not ent	er the mode of o	ying, such	as cardiac c	or respiratory a	arrest,		Approximate Interval Between	
ov i	Physician	i e	Immediate Cause (Final										Onset and Death	
7	/Medical		disease or condition resulting in death)	Due to (or as			IVE PULI	MANUTAR	I DISE	LASE				
	Examiner		Sequentially list conditions, b.											
	pg sit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	Dualto (or se	a consequ	ienes of):								
	and I-trans	xam	that initiated events resulting in death) Last	Due to (or as	a consequ	ence of):								
8760,	cate be executed physician and the burial-transit													
687	ficate physis the	edical	d.										1 7	
Box	feath certific attending p I for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome			7				23	3d. Date of de	livery	
m	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live birth 4 ☐ Pregnant a			∃Ectopic pregna ∃Other <i>(sp</i> ec <i>ify)</i>					Month	Day Year	
P.0.	t the by the	hys	9 Unknown	9□Unknown										
	The law requires that the death certific ate has been signed by the attending prage 2 should be detached for use as	by P	Part II. Other significant conditions cont HYPERTENSION	tributing to death b	ut not resu	ilting in the u	nderlying cause	given in Pa	ırt I.				the cause of death?	
ord	equir	ted								113	Yes 2]No 3∐Pi	robably 4 □Unknown	
ec	law i las be	l De	GENERAL DEBILITY							24a. Was	psy	24b. Were at prior to	utopsy findings available completion of cause of	
<u> </u>		Completed								pen 1□ Yes	ormed? 2 ☐ No	death? 1 ☐ Yes	2 No	
Division or Vital Records,	Attending Physloian: The la r death. ector; Atter this certificate has by the funeral director, page 2	Be	25. Was case referred to medical examiner?	ospital:						(Check only				
o	Phys r this ral dii	٠ <u>.</u>	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Inju		ER/Outpatier 28b. Time o	" OLI DON	463		me 5 ☐ Res 28d. Describe		Other (Spe	ecify)	
on	ding h. After funer	tion	1X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	ıy Year)	Injury		juryat √ork? ∐Yes 2			,			
/iSi	or Attenceath Director; in by the	fica	3 Suicide 6 Could not be determined	28e. Place of inj	ury - At ho	me, farm, str	eet, factory, offic	e		28f. Location	(Street and	Number or R	ural Route Number,	
á	al or safte	Certification:	4 Tromicide	bulluling, e	ic. (Specif)	′)			1	Oily of To	iwn, State)			
	To the Hospital or Attending Ph within E4 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 ertifying Physic (Check only 2 Medical Examin											
	To the H within 24 To the Fi complete	Medical	one)	and manner st										
	To the within To the	2	29b. Signature and title of certifier	45				ense numbe 5217	5 1		∠ya. Date	signed <i>(Moni</i> 8/12/		
)	16		agua	h	donate ()+-	02a) (T		J411 :				0/12/		
R	T		30. Name and address of person who we ADEBOWALE AJAYI, MI	mpleted cause of G D 6201 G	REENB	ELT RI	COLLEG	E PAR	K, MD	20740				
	St	ate		32. Regist										
	Regist		Alig 1 3 2009 2	wa D.	130	West of the second								

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / De	partment of Health and ertificate of Death		0000	07005	
			Registrar 1. Decedent's Name (First, Middle, Last)	- Death	2. Date of Death	eg. No.	3. Time of Death	
	Physicia	an	Adrian Clay MINER		Month	Day Year 15, 2009	8:30 PMM	
	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of De		4c. County of Deat	0	
	Examin	er	18318 Summerlin Drive	Hagerstown		Washingt		
	Funeral	-	5. Social Security Number 6. Sex 7. Age (In yrs. last birthdo	ay) If Under 1 Year If Under 24 H		9. Birti	hplace (State or Foreign	
	Director		214-09-0508 1™ 2□F 93 yrs	Months Days Hours M	lin. (Month, Day, May 26,		vland	
			Usual Residence of Decedent					
	rylan how I at		10a. State 10b. County 10c. City, Town or				10d. Inside City Limits	
	e Ma 3a-f s tiffec	cto	Maryland Washington Hagerst	OWII			1 ☐ Yes 21 No	
	ith th or 28	Director	10e. Street and Number	10f. Zip Code	10	10g. Citizen of What Country?		
	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notifled at	ra	18318 Summerlin Drive	21740		U.S.A.	des Indian	
	tems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Po	' (Specity Yes or No- uerto Rican, etc.)	14. Race - Ame Black, White		
36	s afte	by F	1 □ Never Married 2 ③ Married 1 □ Yes 2 □ No If Yes, Give ₩ • ₩ • ₩ • II Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify:	white	
Maryland 21215-0036	hour fural	ed k	15 Decedent's Education 16a, De	cedent's Usual Occupation		16b. Kind of Business/	Industry	
Ϋ́ Ω	in 72 n "na ledic	Completed	(Specify only highest grade completed) (G	ive kind of work done during most of e. DO NOT use retired)	working		•	
7	with iene. thar	m o	Elementary/Secondary (0-12) College (1-4or 5+)	mechanic		aircraft n	nanufacture	
D	I Hyg other	Be C	17. Father's Name (First, Middle, Last)	18. Mother's N	Name (First, Middle, M	faiden Surname)		
a	lid be lenta ked ked	To B	Oscar Miner		Mary	Weller		
ary	12 should be 1 n and Mental I 1 is marked of raumatic eve		19a. Informant's Name/Relationship (Type. Print) 19b. M	ailing Address (Street and Number or	Rural Route Number,	City or Town, State, 2	Zip Code)	
	1 and 2 Health a em 27 ls	1	Emily F. Miner - wife 183	18 Summerlin Driv	e, Hagerst	own, Maryl	Land 21740	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 20b. Place of Di cemetery,	sposition (Name of crematory or other place)		20c. Location - City or	Town, State	
Ë	Pages nent of h ant: If ite ury or o	1	TEXBURAL 2 Defination 3 Definition State	111 Cemetery Au	gust 19, H	agerstown,	Maryland	
alti	permit. P Departme Importan any Injur	- 8	21. Signature of Funeral Service Licensee	22. Name and Address of Facility	Minnich	Funeral Ho	ome	
m	a m m		tred L. Vestal	415 East Wilson B	lvd., Hage	rstown, Ma	ryland 21740	
	•		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as car	diac or respiratory arre	est,	Approximate Interval Between	
100	Physician	2	Immediate Cause (Final disease or condition	Disease			Onset and Death	
	/Medical		resulting in death) a. Due to as a consequence of):	Disease			Fans	
Г	Examiner							
ij.		ner	Sequentially list conditions, if any, leading to immediate but the following the follo					
	cuted nd ransi	Examiner	Cause (Disease or injury that initiated events					
o	e exe an al	Ä	resulting in death) Last Due to (or as a consequence of):					
8760,	cate be executed oblysician and the burial-transit	ica	d					
ဖ	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE:					
Box	eath certific attending p for use as 1	an/	23b. Was decedent pregnant in the past 12 months?	3 □Ectopic pregnancy		23d. Date of de	livery Day Year	
<u>.</u>	e dea	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)		- Internal	Day Tour	
P.0	that the de ned by the a detached f	Phy	Part II. Other significant conditions contributing to death but not resulting in th	o underlying source given in Part I	23e Did tob	pacco use contribute to	the cause of death?	
ŝ	w requires that s been signed to should be det.	þ	11	s underlying cause given in rain.	1 □ Ye		robably 4 □Unknown	
0	requi	Completed	Trypecronser	•••	_	2 2210	TODADI) 4 GOTINIO III	
ec	e law has b je 2 sl	ఠ		sy prior to	utopsy findings available completion of cause of			
<u></u>	: The	ပ္ပ			perform 1□ Yes 2	med? death? 2 No 1 □ Yes	s 2□ No	
Ĭ,	iclan Sertifi	Be	25. Was case referred to medical examiner?		Death (Check only on	e)		
Or.	Physiclan: r this certificanal director,	ပ္	1 Yes 432 1 1 Inpatient 2 ER/Outpa		-	ence 6 Other (Spe	ecify)	
Ľ.	ing F	ü.	27. Manner of Death 28a. Date of Injury (Month, Day Year) Inju (Month, Day Year)	ry Work?	28d. Describe no	ow injury occurred		
Division or Vital Records,	Attending r death. ector: After by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 280 Place of injury. At home, farm	M 1 Yes 2 No	29f Location (Ct	root and Number or P	uml Pouto Number	
\leq	or Ar	Ħ	4 ☐ Homicide determined 28e. Place of injury - At home, farm building, etc. (Specify)	Street, ractory, office	City or Town	reet and Number or R n, State)	urar noute Number,	
ш	pital ours a eral I		29a. Certifier Certifying Physician: To the best of my knowledge, d	eath occurred at the time, date and r	lace, and due to the c	ause(s) and manner a	s stated	
	Hos 24 ho Fun etely	edical	(Check only one) Check only one) Check only one) Check only one)					
	To the Hospital or Attending Physician: The within 24 hours after death. The Insert Infector: After this certificate ha completely filled in by the funeral director, page	Mec	29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Moni	th, Day, Year)	
	1 3 5		1 07 2 Kl	D68810		Aug - 1 17	2009	
,	140		30, Name and address of person who completed cause of death (Item 23a) (Ty			indin21 11	1001	
	0.		STEVEN BLASH MD 324 E. Antietam St S		Gra now	20740		
	Sta	te		1	,			
	Registi		31. Date filed (Month, Day, Year) AUG 1 7 2009 32. Registrar's Signature	park				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #5 Per FH G895 9/11/4/09 and Department of Health and Mental Hygiene

			1- State State Registrar Certificate of Death		eg. No. 🤈 🦳 🚺	27295
	Physici		1. Decedent's Name (First, Middle, Last)	2. Date of Death	n Day Year	3. Time of Death
	Physici /Media		MARGARET HAUSLER MILLER	August	09 200	
N. S.	Examir	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deat		4c. County of De	
-M		d.	Marriott Courtyard Silver Spring 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs		Montgo	mery rthplace (State or Foreign
П	Funeral Director		5. Social Security Number 199-22-3549 1	(Month, Day,	Year)	Country)
-			Usual Residence of Decedent	02/13/19	926 W11	kes-Barre, PA
	yland how		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	e Mar	ctol	PA Montgomery Bryn Mawr			1 ☐ Yes 2 🗷 No
	ith the	Director	10e. Street and Number 10f. Zip Code	10	0g. Citizen of What C	ountry?
	ath w	ra	601 North Ithan Avenue, #369 19010		υ.	S.A.
	er de	une	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - An Black, Wh	
36	rs aft	by Funeral	1 ☐ Never Married 2 🗷 Married 1 ☐ Yes 2 🗷 No Specify: Year or Dates:		Specify:	White
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Mudical Examiner must be notified at once.	ted	15. Decedent's Education 16a, Decedent's Usual Occupation		16b. Kind of Busines	
215	within 72 iene. 'than "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of working if the DO NOT use retired)	rking		
21	iled wit Hygiene ther the nt, the	Son	4 Homemaker		Don	estic
nd	be filed tall Hyginal distributions of the second of the s	Be (17. Father's Name (First, Middle, Last) 18. Mother's Name	me (First, Middle, N	faiden Surname)	
yla	should be ind Mental i marked c	٩	Charles Hausler	Mathild	a Schegg	
Maryland	2 sh h and is m raum		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Relationship (Type. Print)			• •
	1 and 2 Health Sm 27 i		John Adalbert Miller - Husband 601 North Ithan Avenue		n Mawr, PA	
יסנ	Pages Tent of I Int: If ite		20a. Method of Disposition 1 □ Buriar 2 配 Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	zoc. Location - City o	r Town, State
Baltimore,	it. Page intment intant: It njury o	1 3		L2/2009	Brentwood,	
Ba	permit. Departr Importa any Inju		21. Sign ture of Funer Service Lichser 22. Name and Address of Facility HI 11800 New Hampshir			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia			Approximate
	Division in the second	, ,	shock, or heart failute. List only one cause on each line. Immediate Cause (Final	5201	,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	216		Dimo
- Silvery	Examiner		Due to (1r as/a consequence of):			1,6
		Jer	Sequentially list conditions, if any, eading to instructions, cause. Enter Underlying Cause (Disease or injury that initiated events c.			
	cuted nd ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events			
Ó,	an ar an ar rial-tı		resulting in death) Last Due to (or as a consequence of):			
68760,	tificate be executed g physician and as the burial-transit	/ledical	d			
	E 5. 4	Med	IF FEMALE:		- [-	la la
Вох	Physician: The law requires that the death cer this certificate has been signed by the attendin ral director, page 2 should be detached for use.	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of d Month	elivery Day Year
0	ne de the a	/sic	1 Yes 2 No 9 Unknown		month	Day .ou
σ.	that tl ed by detac		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute	to the cause of death?
ds,	sign d be	d by		1 □ Ye	s 2□No 3□	Probably 4 Unknown
Records,	w requires that the d been signed by the should be detached	Completed		Ode Wee ex	24b Ware	
Re	he law e has ge 2 s	mp		24a. Was ar autops perforn	v prior to	autopsy findings available completion of cause of
ā	ician: The certificate h ector, page		25. Was case referred to medical 26. Place of De	perform		s 2 No
>	Physician: rr this certificant	o Be	examiner?	ath <i>(Check only one</i>	nce 6 Other (Sp	Hotal
o	g Phy er thi eral c	ا: <u>1</u>	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe ho		ecity) J C J
0	inding Fath. r: After ie funera	atio	1 Natural 5 □ Pending (Month, Day, Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No			
Division of Vital	er de recto by th	tific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Sti	reet and Number or I	Rural Route Number,
Ō	tal or rs aft al Dii led in	Certification:	bulang our (epochy)	Dity of rown	, olato)	_
	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral		29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plac 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occ			
	the I	Medical	and mannel stated.			
	5		29b. Signature and title of certifier 29c. License number	29	9d. Date signed (Moi	
	12		Jan 2 7 260 m Dave 12 00 458		100	6000
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Le ricat	Keik L	2 - 63 - 61
	Sta	e .	ILR N BRECKER MODME SILVE, 31. Date filed (Month, Day, Year) 33 Registrar's Signature	Daved	mo	2,3902
	Registr		AUG 12 2009 (). B. Saules	•		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 5:30 PM M Mora Frances 18. AUGUST /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Reeder's Memorial Home Boonsboro Washington If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Italy 89 122-28-8394 13, 1920 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, he Medical Examinations to notified at 1 XYes 2 No Director Washington Boonsboro 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21713 141 South Main Street Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐Yes 2 If Yes, Give 1 ☐ Never Married 2 ☐ Married 2X No 10RA, FRANCES Maryland 21215-0036 1 ☐ Yes 2 No White Specify: þ 3 ₩ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene important: If item 27 is marked other than "any injury or other traumatic event; In Mental Industrial I Elementary/Secondary (0-12) College (1-4or 5+) own home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be Josephine Falasca Louis Cardinale 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11762 Kendallwood Circle, Waynesboro PA 17268 Rose Collins daughter altimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 🗷 Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, Cyril's Cemetery | 08/29/2009 | Rotterdam, NY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Grove-Bowersox Funeral Home, Inc 21. Signature of Funeral Services 50 South Broad Street, Waynesboro PA 17268 23a. Part VEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ADVanced Severe YEARLS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner YEARY Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed YEMIR that initiated events resulting in death) Last Due to (or as a consequence of) burial-P.O. Box 68760, the attending physician hed for use as the burla weeder Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Year Month 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performęd? Yes 2 ☒ No this certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To After thi funeral 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Lirector A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LAPPANS ROAD, BOONSBORO, MARYLAND 21713 301-432-8470 20311 DR. GHAZALA QADIR

State Registrar gistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** August 11, 2009 Estelle MARLOWE 12:20 P ^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Village Health Care Center Gaithersburg Montgomery 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 New York 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours 1 □ M 2√□ F 101-20-5062 Director 1926 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show 1 ☐ Yes 2 No Directo Maryland Rockville Montgomery 10e. Street and Number 10g. Citizen of What Country? 14431 Traville Garden Circle #214D 20850 United States within 72 hours after death Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No white þ Specify: 3 X Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than, Elementary/Secondary (0-12) College (1-4or 5+) Secretary Education permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygic Important: If item 27 is marked other in any Injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) David Lieber Flora Mehlsack 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Marlowe, Daughter 19821 Helmond Way, Montgomery Village, MD 20886 Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 □ Cremation 3 X Removal from State 4 Donation 5 Other (Specify) f F moral ervice Lin Beth El Cemetery 08/14/09 Stamford, CT 21. Signatura Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Cancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Renal Failure Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Day Month Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 📉 No ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed?

1 Yes 2 No certificate director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3□ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation 1 🛚 Natural Injury hours after death.
uneral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H0051280 8-11-2008

State Registrar

AUG 1 2 2009

Anushiravan Dadgar,

30. Name and address of person who completed cause of death (Item 23a) (Type, Pnnt)

D.O., 10110 Molecular

32 Registrar's Signature

Denum B. faces

10110 Molecular Drive, Suite 206, Rockville, MD

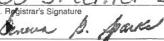
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 10:24 a M Frances M. Myers 09 August 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Carroll Hospice Dove House Westminster Carroll If Under 1 Year | If Under 24 Hrs Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 😾 F 216-26-7891 **Director** July 28 1938 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important: It item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eval. In crust be retified at any injury or other traumatic event, the Medical Eval. 10a. State 10b. County 1 ☐ Yes 2 ☑ No Director MD Carroll Westminster 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21158 USA 300 Falcon Court Apt #2B Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ∐Yes 2 ☐ Mo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 TNo Specify 2 Specify: 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry
Payroll Dept 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Loyola College 12 Paymaster 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Michael Copoulos Bertha Speak 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jack Myers/husband Apt# 2B 21158 300 Falcon Ct Westminster, MD altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Carroll Cremation, Inc 8/13/2009 4 □ Donation 5 □ Other (Specify) Hampstead, MD 21. Signature of Juneral Santo 2711115 Adrine and Chapel, P.A. Mule 412 Washington Road Westminster, MD 21157 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. -1) NICNOWN PRIMARY Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed ending physician and use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) signed by the a 1 ☐ Yes 2 Ø No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown should b Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed this certificate 2 🗆 🗖 1 ☐ Yes 2 1100 Hospital or Attending Physiclan: '24 hours after death.' Funeral Director: After this certifica stely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1∐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 2 **□** No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar

31. Date filed (Month, Day,

30 Name and address of person

29b. Signature ay



and manner stated.

State of Maryland / Department of Health and Mental Hygiene 🚄 🖯

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 9 Day 2009 Year **Physician** 0540 M Henry Michael OBST /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Suburban Hospital Bethesda | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day) | Hours | Min. | May 23, 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 59 1950 France Director 218-56-8161 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Experience must be notified at 1 ☐ Yes 2 ☐ No Director Bethesda Maryland | Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 20817 7555 Spring Lake Drive #C-1 Funeral 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Armed Forces? Black, White, etc. 1 Never Married 2K Married Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: Specify þ white 3 ☐ Widowed 4 XI Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Real Estate Realtor of Health and Mental Hygitem 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fill and Mental h Helen Maurer Maxwell Obst ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7555 Spring Lake Dr., #C-1, Bethesda, MD Matthew Obst, Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 08/Pig09 permit. Pages the Department of Infortant; If ite any Injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Garden of Remembrance Memorial Park Clarksburg, MD 4 Donation 5 □Other ice Lice see 21. Sign thur. eral \$ ใช้หรือที่ให้รู้หรือที่ยื่อง Funeral Home 20012 <u> 254 Carroll St., NW, Washington, DC</u> Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 8716 disease or condition resulting in death) ropayle /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in any, leading to infine flate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): physician P.O. Box 68760 Physician/Medical the signed by the attending r IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>ک</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 221No certificate 1 □Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) this c Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 □ No 2X ER/Outpatient 3 □ DOA 1 Inpatient Certification: To After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural n 24 hours after death.

The Funeral Director: After the function by the function of the funct 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifler 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) m DMX 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KER

Registrar

State

31. Date filed (Month, Day, Year)

AUG 12

Silver

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3. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

Jeanine Werner, 31. Date filed (Month, Day, Year)

AUG 04 2009

			For State Registrar	State o	f Marylar		artment rtificate			and N	/lental Hy	/gien	/	19	27400
	Dhusisi		1. Decedent's Name (First, Midd	le, Last)							2. Date of Do	eath Da	av Y	ear	3. Time of Death
	Physici /Medi		Evelyn Dora Par	ks							Aug	9	2009		10:25P ^M
No. of Street, or other Persons	Examir		4a. Facility Name (If not institution	n, give street and nu	mber)		4b. City, 7	own, or	Location	of Death		40	. County of	Death	
- Andrew		- 1	Dove House				Westn		ter				Carro	011	
	Funeral Director		5. Social Security Number 218-22-8343	6. Sex 1 □ M 2 F	7. Age (In yrs.	last birthday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bi	rth 929 ^{ar}) 9	. Birthpl Count	ace (State or Foreign rry) MD
	pui		Usual Residence of Decedent 10a. State 10b. County	,	100 Ci	ty, Town or Lo	eation	<u> </u>				_		10	d. Inside City Limits
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980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Midlical Evanifier must be rediffed at once.	by Funeral	1 ☐ Never Married 2 ☐ Mar	ried 1 Tyes	rces? 2∰No ve		lfYes, speci 1 □Yes 2		Specify:		ecify Yes or N Rican, etc.)			White, e	
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, Mar	and 2 sho saith and n 27 is ma		19a. Informant's Name/Relations Andrew Parks (s								al Route Numb tminst				Code)
Baltimore, Maryland 21215-0036	Pages 1 annual pent of He sent: If item		20a. Method of Disposition 1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5			Place of Dispo cemetery, crer ke Viev			e) 8		Date 2009		ocation - Cit	•	
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oʻ	cate be executed physician and the burial-transit	Ĕ	resulting in death) Last	Due to (or as a conseq	uence of):									
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.O. Box	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		oirth 2 🗆 Feta nant at time of	aldeath 3	Ectopic pr Other (spe		,				23d. Date of Month		ry Day Year
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Ë	Il or Attending after death. I Director: After d in by the funer	Certification:	3 Suicide 6 Could 4 Homicide determ	ained 26e. Place	of Injury - At h	ome, farm, str fy)	eet, factory,			- 1	28f. Location City or To			or Rural	Route Number,
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in b	Medical C	29a. Certifier 1 Certifyii (Check only one) 2 Medical	ng Physician: To the Examiner: On the band mann	asis of examina	owledge, death ation and/or in	n occurred a vestigation,	t the tim	ne, date ar pinion, dea	nd place, ath occur	and due to the	e cause(, date ar	s) and mann nd place, and	er as st	ated. the cause(s)
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	12		30. Name and address of person	who completed caus	e of death (Iter	n 23a) (Type,	Print)	ノンン	10				V 1 - 1	/	
			Wilby K	10 295	Stov	1	tre s	+ 3	07	W	estani.	rsto	1	10	21157
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	Registr	ar	AUG 1	2 2009	Zenewa	B. 1	back	_							

Amended Item 26 per Phy. 08/06/09 Carroll Co., wjl
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Items 23a,25,27,28a-f per me,g902,04/30/2010dhb
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** Arthur Howard Peck, D.V.M. a^{M} 9:30 August 02 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Carroll Westminster 642 Denton Drive If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Min. Months Days Hours 1 **3** M 2 □ F Yrs Sept 23 1922 86 Director 016-14-2939 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County in than "natural", or items 23a or 28a-f show the Madical Examiner must be notified at Westminster 1 ☐ Yes 2 ☐ XXI Carroll MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21157 USA 642 Denton Drive Completed by Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 □X*es 2 □ No WW
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11 Marital Status WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 □ No Specify Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 Is marked other this any Injury or other traumatic event, Ins. once. Veterinary Medicine Veterinarian 4+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Newberry Peck Lillian Howard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 642 Denton Drive Westminster, MD Barbara Peck/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ *Cremation 3 ☐ Removal from State Carroll Cremation, Inc 8/4/2009 | Hampstead, MD 4 ☐ Donation __5 ☐ Other (Specify) 21. Signature of Juneral Service Licens 22 Project & Address & Facily Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part 1. Enter the of ease, or complications that cause shock, or heart ailure. List only one cause on each ed he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the. **Restrictive Lung Discase** Approximate Interval Between Year and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of)

Diaphragmatic Hernia Years Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). Years Lung Resection Hospital or Attending Physiclan; The law requires that the death certificate be executed APPROVED BY MEDICAL EXAMINER use as the burial-tran and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Shrapnel Injuries Years Physician/Medical CERTIFICATIO IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown signed by to 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has t autopsy this certificate 1 □ Yes 2 □ 1 10 25. Was case referred to medical Be 26. Place of Death (Check only one) miner examiner: 1A Yes 9 € No Other: 1 Inpatient 2 ER/Outpatient 3 DOA → 5 K Residence 6 □ Other (Specify) Certification: To 27. Manual of Death funeral 28a. Date of Injury (Month. Day Year) 28b. Time of 28d. Describe how injury occurred
Subject struck by shrapnel 28c. Injury at After Injury 5 ☐ Pending investigation Tural 1 AYes 2 □ No 11/30/1944 ours after death.

leral Director; A
filled in by the fu death. 2 Accident **Unknown**^M during combat. 6 ☐ Could not be 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Field Near Weinbourg, France within 24 hours a
To the Funeral C 29a. Certifier HC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number WJZ 10059943 2009 6+IVA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 295 Binn (wes minster 31. Date filed (Month, Day, Year) 32. Registrar's Signature State park Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** Mabel Lorraine Prohaska AUGUSI PM 2009 /Medical 4c. County of Death 4a. Façility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CHARI A I A If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Voor Months Days 1 □ M 2 🗓 F Hours 577-42-2684 Director May 1. 1932 Washington, DC Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Wadfoel Evaniner must be notified at once. 10a. State 1 ☐ Yes 2 No Director Charles LaPlata Maryland 1 Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20646 1 Magnolia Drive #131B USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2√X No Specify. White þ Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Edward **Jourdant** Olive Marie Padgett 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Ladd Prohaska Jr. / Son 410 Carriage Lane Huntingtown, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XXX Burial 2 Cremation 3 Removal from State Washington Nat. Cemetery 08/14/2009 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signatur of Fune Service Licenses George P. Kalas Funeral Home P.A. Kh 6160 Oxon Hill Road Oxon Hill, Maryland 20745 23a. Farth. Enter the disease, or complications that caused the death. Do not enter the managed the death. Do not enter the managed the death. Approximate Interval Between Onset and Death Immediate Cause (Final Physician NON disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed burial-tran and (or as a consequence of): the attending physician hed for use as the burial Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2/2/No 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner' 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No ; after death. I Director: ≠ 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) þ determined 4 Homicide To the Hospital within 24 hours a To the Funeral I Hospital Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Maryland 21215-0036

ORRAIN

PROHASKA

Baltimore,

Division of Vital Records, P.O. Box 68760,

State Registrar

Medical

filed (Month. Dav AUG 1 3 2009

29b. Signature and title of certifier

and address of

(Check only one)

32. Registrar's Signature

who comple

9c. License number

29d. Date signed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Flossie M. Padilla Ρ. 2009 5:35 /Medical August 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Villa Rosa Nursing Home Mitchellville Prince George's If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours 1 □ M 2 🛛 F 87 Director 12/14/1921 0K 441-28-0710 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show the Medical Exertiner must be notified at 1XYes 2 No Director Prince George's Mitchellville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 20721 IISA 2706 Millwood Way Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Black 1 □Yes 2X No Specify: \$ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 1.2 Public School/Education 6 Teacher permit. Pages 1 and 2 should be filed Department of Health and Mental Hygin Important; If item 27 is marked other any injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Adolphus Parker Isabelle Carter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Shirley C. Dixon/Sister 2706 Millwood Way, Mitchellville, MD 20721 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection 08/15/2009 Clinton, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd., Camp Springs, MD 20748 d Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ualietes disease or condition resulting in death) Years /Medical Due to (or as a consequence of): Examiner neum Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe certificate 1 ☐ Yes 2 ☐ No 2 No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: d in by the 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 24 hours e Funeral 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. Nurse Practitioner 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14300 Gallant Fox Suite 222 Bowie, MD20715 Jarrell, CRNP

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Records,

of Vital

Division

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 2009 1er undie /Medical 4c. County of Death 4b. City, Town, or Location of Death Name (If not institution, give street and number) Examiner Cheverly George's Hosp, tal Cenkr | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Sex 1XM 2□F **Funeral** 12009 NO Ne Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State item 27 is marked other then "natural", or Items 23s or 28s-f show other traumatic event, the Michigal Examinations to notified at 1 Yes 2 No **Funeral Director** Krince George's Landover Hills 10g. Citizen of What Country? 10e. Street and Number 20784 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If them 27 is marked other then "ne eny injury or other traumatic event. The Tables. (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) NONE-10 Ne-INTAN NONE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 10NYA Price-UNKNOWN 19b. Mailing Address (Street and Num er or Rural Route Number, City or Twn, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) AKPAN mother 38216 4th Ave #3 Landover Hills MD 20784 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Cheverly 4 Donation 5 Other (Specify) Co. D.Sp. Hince Georges Hosp 22. Name and Address of Facility Hospital Prince Georges Hos MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury by Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day detached for 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. the funeral director, page 2 should be 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 💢 No 24a. Was an autopsy performe 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 X Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To this 28a. Of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Leath 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and Alle of certifier 268 5-2009 Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Hospital Dr. Cheverly
32. Registrar's Signature Chaudr

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) AUG 26 200

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- 4.	/Medi				Romard			T			August	1	2009 County of Deal		30 A ^M
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ore	es 1 a of He fitem		20a. Method of Dispositi		D	20b. F	Place of Dispo cemetery, crei	osition (Name of matory or other place	ce)	Di	ate	20c. L	ocation - City or	Town, State	
altimore,	Pag nient ant: I		1 □ Burial 2 □ Cre 4 □ Donation 5 □				ayview	Cremator	У	8/5/2	2009	Balt	timore,	Maryla	and
Balt	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other traumatic event, the Myonce.		21. Signature of Funeral	I Service Licer	see			2. Name and Addre		. 176			al Home 0 20715		
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_	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b		29a. Certifier	Certifying Ph	ysician: To the be	st of my kno	owledge, dea	th occurred at the ti	ime, date	e and place,	and due to the	e cause(s) and manner a	as stated.	
	n 24 h	Medical	(Check only 2 one)	Medical Exam	niner: On the basis and manner	s of examina	ation and/or i	nvestigation, in my	opinion,	death occurre	ed at the time	, date an	d place, and du	e to the caus	e(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year <u>AUGUST</u> 10, 2009 /Medical PAUL RICE 8:00 Α 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 4b. City. Town, or Location of Death ST. THOMAS MOORE NURSING HOME HYATTSVILLE PRINCE GEORGE"S If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. | 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1⊠M 2□ F 72 Director Union, 250-62-9266 5/29/1937 SC Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f show Director 1X Yes 2 □ No Maryland Montgomery Takoma Park 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6733 New Hampshire Ave. #401n 1 and 2 should be filed within 72 hours after death Health and Mental Hygiene. em 27 is marked other than "natural", or items 23. Funeral 20912 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🕅 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🙀 No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Stock Clerk Private other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Rice Corie Dawkins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earnestine Rice / Wife 6733 New Hampshire Ave. #401N Takoma Park, MD 20912 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or otl 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans 8/18/2009 Cheltenham, Maryland 21. Signat / e of Funeral Service Livensee 22. Name and Address of FacilityPope Funeral Homes, P.A. 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 5538 Marlboro Pike Forestville, Maryland 20747 Approximate Interval Between 3 weeks erebual in Eguction **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Interiosalerotic Candiovasulus Diase Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): and burial-tra Due to (or as a consequence of): Box 68760, the attending physician hed for use as the buria The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 0 5 ☐ Other (specify) ☐Yes 2☐No detached 9 D Unknown 9 Unknown signed by ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ₫ typer Tonsion 1 Yes 2 No 3 Probably 4 nknown Completed peen buillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Ventilator Depludin certificate Reinirustry 2 □No 1 ☐Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) rthis c Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2**ॉ**No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation L Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) censbury Rd Hyattsvill MD 20181

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend, Item 25 per phys. G895 9/3/09 dk

		For State Registrar	State of Ma		aftment of Hea tificate of Dea	lth and Mental ath	Hygien Reg. N		274.0
Physici /Medic		1. Decedent's Name (First, Middle, Las		SI	ECKER	Auc	145+ 1	Day Year Year	3. Time of Death
Examin		4a. Facility Name (If not institution, give The Johns Hopkins H	ospital	•	4b. City, Town, or Local Baltimore Ci		•	c. County of Death Baltim	
Funeral Director			M 2 G F	e (In yrs. last birthday) 57 Yrs.		ours Min (Mon	th, Day, Year, 26,19	952 Pen	place (State or Foreig ntry) nsylvania
Maryland I-f show ied at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Washing	ion	10c. City, Town or Lo					10d. Inside City Lim 1 ☐ Yes 2X
n with the	Funeral Director	10e. Street and Number 10231 Summers Lan	ne		10f. Zip-Code 2174	0		Citizen of What Cour	ntry?
ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 XI If Yes, Give Year or Dates:	No I		nic Origin? (Specify Yes exican, Puerto Rican, et opecify:	or No- c.)	14. Race - Americ Black, White, Specify:	can Indian, etc. white
within 72 ho ene. than "natura te Medical E	Completed	15. Decedent's Er. (Specify only highest gra		(Give	dent's Usual Occupation kind of work done durin DO NOT use retired) ntenance	n g most of working		Kind of Business/Ir	
should be filed within and Mental Hygiene. marked other than matic event, the ME	To Be Co	17. Father's Name (First, Middle, Last) Theodo:	e Siecke			Mother's Name (First, A	Aiddle, Maid		
and 2 should be faith and Mental H 27 is marked of er traumatic ever		19a. Informant's Name/Relationship (18 Beverly A. Siecke		1	9	Number or Rural Route Lane, Hager	stown,	Maryland	1 21740
permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification of Specification of Specific)	Rose Hill	natory or other place) Cemetery 2. Name and Address of	8-19-09 Facility Minr	Hag nich F	erstown, uneral Ho	Maryland me
Physician /Medical Examiner	ner	23a. Part 1. Enter the disease, or company shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a. Pncur Due to (or as	the death. Do not ente. Yonio a consequence of):	er the mode of dying, s	uch as cardiac or respira	atory arrest,		Approximate Interval Between Onset and Death
The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edical Examiner	cause. Enter Underlying Cause. (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a_consequence of):		· .			
he death certific the attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□ Ectopic pregnancy □ Other (specify)			23d. Date of deliv Month	rery Day Year
w requires that the dea been signed by the at should be detached for	ρ	Part II. Other significant conditions of	ontributing to death b	ut not resulting in the	underlying cause given	in Part I. 23e		o use contribute to	
	Completed	CC West and the state of the st				1 🗆	Was an autopsy performed?	prior to co	opsy findings avail ompletion of cause 2 No
Physician: The this certificate are director, pa	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	nt 2 ER/Outpatier	Othor	Place of Death (Check		6 ☐ Other (Special	fy)
ling. After fune	Certification: 1	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not b	-		M Work? 1 ☐ Yes	2 🗆 No		jury occurred and Number or Rui	ral Route Number,
하를		4 Homicide determined	building, etc	c. (Specify) of my knowledge, death	n occurred at the time, o	City	to the cause	e(s) and manner as	stated.
To the Hospital within 24 hours a the Funeral I completely filled	Medical	29b. Signature and title of certifier	niner: On the basis of and manner sta	examination and/or in ated.	29c. License nur			Date signed (Month,	
5		30. Name and address of person who Rina Khatri					Wolfe	St, Baltimo	re, MD, 21
Sta Registr	te ar	31. Date filed (Month, Day, Year) AUG 17 2	109 Sense	r's Signature	and			,	

Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Joan Mutty Symington 2009 9:15 A^{M} 11. August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Elizabeth Manor Assisted Living Lanham Prince George's If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 🖾 F 83 006-20-8082 Director February 27, 1926 Maine Usual Residence of Decedent 10a State 10h County 10c, City, Town or Location 10d. Inside City Limits iten 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Maddall Examiner must be notified at 1 X Yes 2 No Director Maryland Prince George's Seabrook 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6912 Lyle Street 20706 **JISA** Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No þ Specify: White 3 ☐ Widowed 4 🖾 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Magnee. Elementary/Secondary (0-12) College (1-4or 5+) Telephone Company Customer Service / Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Edward Mutty Wena Lynch ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy Mutty / Sister 6912 Lyle Street, Seabrook, MD 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 8/11/2009 Alexandria, Virginia 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 FAY Kugars 23a. Part 1 Enter the deease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Dementia disease or condition resulting in death) 4 Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (uiscass or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): physician a s the burial-O. Box 68760, Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ☐ Live birth 2 ☐ Fetal death in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Chronic Pain Syndrome 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown s been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Osteoporosis 24a. Was an autopsy performed? certificate 2 X No 1 □ Yes or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Mother (Specify) Hospital: 1 ☐ Yes 2 🔀 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury 1 X Natural 5 Pending death. ours after death.
neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide Hospital 24 hours a 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Je 0 D37934 8/11/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephanie Trifoglio, 7500 Greenway Center Drive, Suite #430, Greenbelt, MD 20770 32. Regist ar's Sign State Registrar

State Registrar who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Molor Dopodula

31. Date filed (Month, Day, Year)

C10001802

State of Maryland / Department of Health and Mental Hygiene

			For State of Maryland 1 - State Registrar	•	rtificate of Death		Reg. No. 2	9 274 12
ı	Physici	an	Decedent's Name (First, Middle, Last) PATRICIA D. TAYLOR			2. Date of D	T 1, 2009	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location o		4c. County of D	04:34 P. M
	Examir	er	2744 GINGERVIEW LANE		ANNAPO			ARUNDEL
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. la:	st birthday)	If Under 1 Year If Under 2	24 Hrs. 8. Date of B		Birthplace (State or Foreign
	Director		218-54-9535 1□ M 2 F 59 Usual Residence of Decedent	Yrs.	Months Days Hours	Min. (Month, L	R 1, 1949	MARYLAND
	aryland show			Town or Lo	cation			10d. Inside City Limits
	e Mar la-f sl	Funeral Director	MARYLAND ANNE ARUNDEL		ANNAPOLI	S		1 □Yes 2 No
	or 28	Dire	10e. Street and Number		10f. Zip Code		10g. Citizen of What	Country?
	ath w	ā	2744 GINGERVIEW LANE		2140	1	UNITED	STATES
	tems	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. 13. \	Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican	gin? (Specify Ye's or N , Puerto Rican, etc.)	o- 14. Race - A Black, W	merican Indian, hite, etc.
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygene. Item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, it We don! Examiner must be notified at	þ	1 ☐ Never Married 2 📉 Marrled 1 ☐ Yes 2 📉 No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		1 □Yes 2 No Specify:		2 "	VHITE
5-0	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)		dent's Usual Occupation kind of work done during most	of working	16b. Kind of Busine	ss/Industry
121	ithin ne.	mple.	Elementary/Secondary (0-12) College (1-4or 5+)	life. L	DO NOT use retired)	or working		
	iled w Hygie ther t		1. Father's Name (First, Middle, Last)		HOMEMAKER	r's Name (First, Middl		HOME
Maryland	S should be filed within and Mental Hygiene. Is marked other than aumatic event, Inc.) Be	COLEMAN LEONARD DIAMOND				e, maiden Surname)	
Z.	should I and Men s marke umatic	은	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	ng Address (Street and Numbe	LY WOLF or Or Rural Route Num	ber. Citv or Town. State	e. Zip Code)
	1 and 2 s Health ar em 27 is other trau		SARAH E. SCHOENTHAL/DAUGHTER		GINGERVIEW LA		•	
J.	ges 1 ar t of Hea lf item or other		20a. Method of Disposition 20b. Pla	ice of Dispo	sition (Name of	Date	20c. Location - City	
Ë	Pages ment of I ant; If ite		1 Burial 2 □ Cremation 3 □ Removal from State BE 4 □ Donation 5 □ Other (Specify) PA		A MEMORIAL	UGUST 6, 2009	ANNAPOLIS	MARYT.AND
Baltimore,	permit. Page Department Important; If any injury o		21. Signature of Funeral Service Licensee M00672		Name and Address of Facility REMATION AND FOLIS ANNAPOLIS		HELFENBEIN E. P.A., 8	AND NEWNAM 14 BESTGATE
			23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not ent	er the mode of dying, such as	cardiac or respiratory	arrest,	Approximate Interval Between
	Physician	(Q - 4	Immediate Cause (Final disease or condition	do	ti. Can	eer -		Onset and Death
	/Medical		resulting in death) Due to (or as a consequence)	nce of):		er -		
	Examiner	L	Sequentially list conditions, b.	volo	Men De	real	o 	
	ted isit	ıjne	Sequentially list conditions, and the sequential sequen	ence of:				
	execur and al-trar	Examiner	that initiated events resulting in death) Last C	ence of);				
68760,	death certificate be executed e attending physician and id for use as the burial-transit			,				
	tificati ig phy as the	dedical						
Box	eath cer attendin for use		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal of		Testenia pragnanau		23d. Date of	delivery
	ed for	Physician/	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of dea		Ectopic pregnancy Other (specify)		Month	Day Year
PO	that he de ned by the deta hed	Phy	9 Li Onknown	t		age Did	1-1	At the same of death 0
Records,	es jo	þ	Part II. Other significant conditions contributing to death but not result	ing in the ur	nderlying cause given in Part I.			to the cause of death? Probably 4 Unknown
50	w requir been s should	ompleted				24a. Wa		autopsy findings available
Re	The law ate has page 2 s	dmo				auto	opsy prior death	to completion of cause of
	iclan: T certificat ector, pa	ပိ	25. Was case referred to medical		OC Disease	100		es 2□No
>	Physiclan: this certific ral director, I	m	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 El	R/Outnatien	Othor	of Death (Check only	sidence 6 Other (S	
	ding Phy h. After thi funeral o	ը 건	27. Manne Death 28a. Date of Injury 2	28b. Time of	28c. Injury at		how injury occurred	респу)
<u>.</u>	Attending r death. sctor: After by the fune	atio	1 ✓ atural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident investigation	Injury	Work? M 1 □Yes 2 □ N	No		
Division		Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	eet, factory, office	28f. Location City or To	(Street and Number or own, State)	Rural Route Number,
-	Hospital or 24 hours afte Funeral Dir tely filled in		29a. Certifier 1 ertifying Physician: To the best of my knowl	ledge, death	Occurred at the time, date an	d place, and due to th	e cause(s) and manno	r as stated
	e Ho: n 24 h e Fur letely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	on and/or in	vestigation, in my opinion, deal	th occurred at the time	e, date and place, and o	lue to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier		29c. License number		29d. Date signed (Mo	onth, Day, Year)
			Cuti Ham	-,49	0 53	306	8/3/	09
	112	ŀ	30. Name and address of person who completed cause of death (Item 2	23a) (Type, I	Print)		//_	- /
权)	710		Curfis Harris, mo 900	Best	tgate Rd	870310 H	nnapolis	m1 2140
	Stat	_	31. Date filed (Month, Day, Year) 32. Registrar's Signatur	re	1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 29d per phys. G895 9,1709 dk. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician 8:25A M Joseph S. Torney III /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not Institution, give street and number) Examiner Salisbur Coastal Lake Wicomico HOSDICE at the If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. **1**√2 M 2 □ F 212-40-9687 Mar 15, MĎ **Director** 68 1941 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Eval: the must be multiled at 1 ¥Yes 2 □ No Director MD Wicomico Delmar 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9365 Stage Road 21875 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2x No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: Black 1 ∐Yes 2 XNo Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 7 is marked other than traumatic event, the traumatic event, the traumatic event, the traumatic event, the traumatic event that the traumatic event the traumatic event that the traumatic event the traumatic event that the traumatic event that the traumatic event the traumatic event that the traumatic event that the traumatic event that the traumatic event the traumatic event that the traumatic event that the traumatic event the traumatic event that the traumatic event that the traumatic event that the traumatic event the traumatic event that the traumatic event the traumatic event that the traumatic event that the traumatic event that the traumatic event that the traumatic event the trau Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. 12 Bus Driver Transportation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph S. Torney, Jr. ပ Viola Toastin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any injury or other trau
once. Annie Teresa Torney/wife 9365 Stage Road, Delmar, MD 21875 20b. Place of Disposition (Name of cemetery crematory or other place)
Springhill 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/13/2009 Memory Gardens | 8/ Salisbury, MD 21. Signature LF Teral Service Licensee Lewis N. Watson Funeral Home, PA 1618 West Rd., Salisbury, MD 21801 Talana P 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HRPATO CRUMLAN **Physician** CARCINOWA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Que to for as a nonsequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown , page 2 should Be Completed Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 1 □Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 Hother (Specify) Hostica Z∐No 1 ☐ Yes Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 1 28c. Injury at Work? 5 Pending 1 □Yes 2 □ No Z ☐ Accident investigation within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00058410 August 9, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAUSBURY US PO BOX 1733 EHULAM 31. Date filed (Month) 32.-Registrar's Signatu State

Registrar

			For State Registrar	State of	Maryland		artment of H tificate of D			giene _{Reg. No.} 2 (100	271.11
			Decedent's Name (First, Middle)						2. Date of Dea	ath	V	3. Time of Death
	sicia edic		Charmaine	Bond	Walker				Month 08	06	2009	6:07 PM
	min	er	4a. Facility Name (If not institution		ber) ·			Location of Death		4c. Count	y of Death	
			The Johns Hopkins 5. Social Security Number		7. Age (In yrs. las	t hirthday)	Baltimore If Under 1 Year	City If Under 24 Hrs.	8. Date of Birt	h	1 9 Birthr	lace (State or Foreign
Fune Direc			212–62–9859	1 M 2 XF	7. Age (iii yis. ias	Yrs.	Months Days	Hours Min.	(Month, Da	y, Year) • 1953	Count	YLAND
		ļ	Usual Residence of Decedent		1			1				
aryland show	i ai	5	10a. State 10b. County		10c. City,	lown or Lo		LTIMORE				0d. Inside City Limits 1X Yes 2 □ No
the M 28a-f	enno	Director	MARYLAND 10e. Street and Number				10f. Zip-Code			10g. Citizen of	What Cour	try?
with 3a or	ad 1		1543 HOLBRO	OK STREET				21202	1	UNITE	D STA	TES
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. ther than "antural", or items 23a or 28a-f show		Funeral	11. Marital Status	Armed For	dent Ever in U.S.	13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spo n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	I Bla	ce - Americ	etc.
36 safter	amine	by Fu	1 Never Married 2 Narr 3 Widowed 4 Divorced	I IT YES TAIVE	5		1 ☐ Yes 2X No	Specify:		Speci	AFRI	CAN
21215-0036 d within 72 hours aft giene. gr than "natural", or	EX		15. Deceden	nt's Education			dent's Usual Occup			16b. Kind of		MERTCAN dustry
215	Medic	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed) College (1-4	4 or 5+)		kind of work done of DO NOT use retired		ang	DI IDI I		D 3 D 1 7
d 212 filed with Hygiene.	, me	Con	47 5 11 1 11 11 15 14 15 14 15	11_		LI	BRARY TEC	THNICIAN 18. Mother's Nam	o /First Middle		C LIE	RARY
Maryland Id 2 should be file Ith and Mental Hy 27 Is marked oth	even	Be	17. Father's Name (First, Middle, MAURICE JACKS)	,				BARBARA		, ividiueri Surria	me)	
arylan should be nd Mental	шапс	မ	19a. Informant's Name/Relations		-	19b. Maili	ng Address (Street			er, City or Town	, State, Zip	Code)
, Mar and 2 sho saith and n 27 is m	Litan		CHARLES F. WALL	KER / HUSBA	AND	1543	HOLBROOM	K STREET,	BALTIM	ORE, MA	RYLAN	D 21202
iter iter	ome	İ	20a. Method of Disposition 1 Burial 2X Cremation	3 Pemoval from S	0.05	ce of Dispo	osition (Name of matory or other place	e) !	Date	20c. Location	- City or To	wn, State
Pages ment of l ant: If ite	ury o		4 Donation 5 Other (S	Specify)	R.A.		is & co.		11/09		CHES	TER, PA
Baltimo permit. Page Department (Important: If	any in		21. Signature of Funeral Service	Licensee	Do no	2	2. Name and Addre LISA SC 552 LEW	ss of Facility YTT FUNER IS STREET	AL HOME • HAVRE	P.A. DE GRA	CE. M	D 21078
			23a. Part 1. Enter the disease, or shock, or heart failure. List			Do not ent						Approximate Interval Between
Physici		i	Immediate Cause (Final disease or condition	Arti	hrosclerot	ic C	ardiovasc	ular dise	rase			Onset and Death 5 - lo years
/Medic			resulting in death)		or as a conseque							
		er	Sequentially list conditions,	b	UF 85 & CORSICUE	nce off:					-	
ted	IISII	Examiner	it any, trading to immediate cause. Enter Underlying Cause (Disease or injury		,	,						
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8760, cate be executed physician and	ng au	edical		d								
entifica	(2)	/Me	IF FEMALE:	23c If yes out	come of pregnance	~V				204 5		
I Records, P.O. Box 68 The law requires that the death certific the has been signed by the aftending is	TOT US	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live b	oirth 2 Tetal o	death 3	_ Ectopic pregnanc _ Other (specify)	у			ate of deliving a contract of the contract of	Day Year
P.O. I	acned	hysi	1 Yes 2 No 9 Unknown	9 🗌 Unkno	own							
S, P.	ac dec	by P	Part II. Other significant conditi		eath but not resul	ting in the	underlying cause gi	ven in Part I.				the cause of death?
ord;	pino		Hypertensia						1 12			oabiy 4 🗌 Unknown
Recor	N I	Completed	Diabetes	Mellitus					24a. Was autoj	an 24b psy ormed?	b. Were auto prior to co death?	opsy findings available ompletion of cause of
a F	r, pag		25. Was case referred to medical					oo Disas of Death	1 Yes	2 🗌 No		2 🗆 No
Vit Slcian certifi	llrecto	Be	examiner? 1 Yes 2 No	(Incombate	npatient 2 🗹 E	R/Outpatier	nt 3 DOA Oth	26. Place of Deat er: 4 □ Nursing Ho			ther (Specif	(v)
Phy a Phy er this	leral d	n: 70	27. Manner of Death	28a. Date o	·	28b. Time o		y at		how injury occi		,,
SiOr andling ath. ir: Afte	ne Tur	atio	Z / tooldorit	igation	n, Day roar,	jairy		Yes 2 □ No				
Division of Vital Records, or Attending Physician: The law requires that deer death. Director: After this certificate has been signer to the control of the	n by r	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	ninod 200. I lace	of injury - At hom ng, etc. (Specify)	e, farm, str	eet, factory, office		28f. Location (nber or Rur	al Route Number,
Division of Vital Re To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funcial Director: After this certificate has	Dellii			ng Physician: To the								
e Hos	Dietely	Medical	(check only 2 Medical one)	i Examiner: On the ba and mann	asis of examination ner stated.	n and/or ir	vestigation, in my o	ppinion, death occu	rred at the time	, date and plac	e, and due	to the cause(s)
vithin to th	E OS	ž	29b. Signature and title of certifie		- 1 0		29c. License			29d. Date sign		
			Ganzhen					-000		08/1	0/200	7
_2	<u></u>		30. Name and address of person ANG	who completed caus	se of death (Item	23a) (Type	, Print)	600	North Wo	olfe St, B	altimo	re, MD, 21287
Re	Sta gistr		31. Date filed (Month, Day, Year) AUG 12		egistrar's Signatur	bar	K					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Month **Physician** 2009 5:31 August AM JOHANNESEN WISE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICAL If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

May 1, 1921 FREDERICK MEMORIAL HOSPITAL FREDERICK 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖾 F 043-14-4343 88 **Director** Connecticut Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show 10a. State 10b. County item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Wedical Examinar must be notlined at Director 1 ☐ Yes 2 ☑ No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21704 5955 Quinn Orchard Road United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 to respond to the service of the s Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married .2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐Yes 2X No Specify Specify: White þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Real Estate Elementary/Secondary (0-12) College (1-4or 5+) Secretary es 1 and 2 should be filed w of Health and Mental Hygier fitem 27 Is marked other tt Appraisa1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carl Johan Johannesen Hannah Fredricke Bergstrom 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Wise / Daughter 122 Fairview Ave., Frederick, MD 21701 permit. Pages 1 a
Department of He
Important: If item
any Injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) August 10, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Crematory 2009 Frederick, Maryland 21. Signature Juneral Service Licensee Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 Paul. Enter the disease, incomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Find disease or condition resulting in death and io my opath **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Liter or denying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical the attending p IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) signed by the a P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Fibrillahion 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy page performe certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: this certific al director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1□Yes 2☑No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) After th funeral 27. Manner of Death 1 Augustual 2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending hours after death.
uneral Director: A
sly filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number D60417

6+1

State Registrar

31. Date filed (Month, Day, Year)

Hemen

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

shah

MD

65

C

Tohnson

09-0635	7		
Douglas	Farl	White	

Please 1

Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.	2009	27415)
Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.		communify of the first	-
State of Manyland / Department of Health and Mental Hygiene			

		- For State Registrar		(Certifica	ate of I	Death	_				Reg. No.		
Physicia		 Decedent's Name (First, Middl 									Date of De Month	Day	Year	3. Time of Death
edical Exami	ner	Douglas	Earl W	hite							August 1	3, 2009	9	2120 hrs
		4a. Facility Name (if not institution	n, give street and	I number)		4b	. City, Tov	n, or Lo	cation of I	Death			County of Dea	th
		Route 491 @ Pleasar	nt Valley Inter	section		l l	Smithst	ourg					Vashington	
Funeral		5. Social Security Number	6. Sex	7. Age (In	yrs. last birtl	nday)	If Under		If Under :	24Hrs.	8. Date of B	irth (MM/	DD/YYYY) 9. B	sirthplace (State or Foreign country)
Director	- 1	183-56-8932	1 X M 2	_F 4'	7	Yrs.	Months	Days	Hours	Min.	0cto	ber	10 Per	nnsylvania
	L	Usual Residence of Decedent	TALIW Z	-							1901			
any	H	10a. State 10b. County		10c.	City, Town	or Locatio	n							10d. Inside City Limits
*		Pennsylvania	Frank1	in	Wayn	esho	oro							1 Yes 2 X No
Maryland 28a-f show d at once	흱	10e. Street and Number	TIGHAL		na _j n		10f. Zip C	ode		-		10g. Citi	zen of What Co	untry?
Mar r 28a	Director		_			i							1103	
ith the Maryland 23a or 28a-f sho notified at once		9330 Gap Ro				1 10 111		268	la Ostala	2/5-2	sift Van as N	lo T	USA	erican Indian, Black,
h wii ems	era	11. Marital Status 1 Never Married 2 M		Decedent Ever d Forces?	in U.S.	13. Was	s Decedent s, specify	or Hispa Cuban, I	Mexican, F	Puerto R	cify Yes or Nican, etc.)	"	White, etc.	prodri malan, bladi,
or it	Funeral		1 Ye		No			J					Specify: W	hite
after ral",	à		orced If Yes, Give		-d\ 160		Yes 2			nd of wo	rk done	16b	Kind of Busines	s/Industry
9036 within 72 hours after iten. Medical Examiner		15. Decedent's Education (Spe			100.	during mo	st of worki	ng life. D	DO NOT u	se retire	d)			,
36 In 72 Iteal	Completed	Elementary/Secondary (0-12)	Colle	ge (1-4 or 5+)		D 1						l Tra	evern/	Pub
with with grene ner tl	E	12 17. Father's Name (First, Middle	Lact)			вагт	tende	<u>er</u> 18	3.Mother's	Name (First, Middle			
filed Hyged of	Ö	Richard E.								,	et M			
21215-0036 uld be filed within 72 hours Mental Hygiene. marked other than "natu c event, the Medical Exam	O O	19a. Informant's Name/Relations			19	b. Mailing	Address	(Street					City or Town, Sta	ate, Zip Code)
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiewith and them 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	ř	Cynthia W.N			1 1									ryland 21783
MD and 2 sho salth and em 27 is		20a. Method of Disposition	Olan (DISCEL	20b. Place					LVUI	Date	20c.	Location - City	or Town, State
Ore es 1 a of He If it	ΠÏ	1 Burial 2 X Crematio	n 3 Remov	al from State	cremat	tory or oth	er place)			8/1	7/2009	3 Sm	ithshur	g, Maryland
ime Pag nent lant: or of		4 Donation 5 Other S	Specify:		Smith	sbur	q Cre	emate	$\operatorname{ory}_{\perp}$					
Baltimore, MD 21215-003 Departir Pages I and 2 should be filed within Department of Health and Montal Hygiene. In protrant: If item 27 is marked other the injury or other traumatic event, the Med		2 . S nature of Fun ral Fervice	Licensee	M-06	849									1 Home, Inc.
m #9 = "		Jane 1. DOC	helam	Par	<u>'</u>	48	S. C	hur	ch St	ree	t, Way	ynes!	boro, P	ennsylvania Approximate Interval
Physician		23a. Part I. Enter the disease, o failure. List only one cause	r complications the on each line.	nat caused the	death. Do n	ot enter th	ne mode of	ayıng, s	uch as ca	ruiac oi	respiratory	an est, sn	iock, of ficalt	Between Onset and Death
/Medical aminer		Immediate Cause (Final disease												Deau
		or condition resulting in death)	Due to (or	as a conseque	ince of):									
	- I	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a conseque	ence of):									
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated		_										
- i	xar	events resulting in death) Last	Due to (or	as a conseque	nce of):									
760, ficate be executed g physician and s the burial - transi			d											
760, cate be execut physician and	ואי/Medical	UNPENDED	AMEND	ED			_							
ਲ ਫ਼ ਦੁੰਦ	/Me	IF FEMALE: 23b. Was decedent pregnant in	Alba 🗀	yes, outcome o	f pregnancy			0	Catania		201	23	3d. Date of delive Month	very Day Year
68° certifi iding se as	ian	past 12 months?	,	ive birth Pregnant at time	C -l Ala	2 Fe		3 _	Ectopic	pregnar	icy		MOHUT	Day Tool
Box 687 ne death certific the attending p	sic	1 Yes 2 No 9 Ur	-1	Jnknown		5 Oti	her (Speci	·y)						,
the d	Physiciar	Part II. Other significant cond		ing to death bu	t not resultir	ng in the u	underlying	cause gi	iven in Pa	rt I.	23e. Di	d tobacco	o use contribute	to the cause of death?
P.O.	þ										1	Yes 2	√ No 3 F	Probably 4 Unknown
18, quire en sij uld b	Completed										24a. W			e autopsy findings available
OFC aw re nas be 2 sho	l d											itopsy erformed?		to completion of cause of
Rec The I	Į Š										1 🗸 Ye	s 2	No 1 ✓	Yes 2 No
an:	Be	25. Was case referred to medic					2		of Death					
Vita nysici this c	. E	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient	2 ER/0	Outpatient			Other4		g Home 5		dence 6 🗸 O	ther: Scene
Division of Vital Records, tal or Attending Physician: The law requir as after death and Director. After this certificate has been seled in by the fureral director, page 2 should be the funeral director, page 2 should a	- L	27. Manner of Death	28a.	Date of Injury Month, Day Year) 113, 2009		. Time of I	Injury 2	_	y at Work		28d. Descri Driver of	be how in	njury occurred	guardrail
on tendi	tio		nding Aug restigation	13, 2009	1000	00 hrs		1 Y	'es 2 ✔	No				
VISI or Att her de in by	lice Lice		uld not be	Place of Injury	- At home,	farm, stre	et, factory,	office b	uilding, et	c.				r Rural Route Number, City
Disal curs at Illed	Certification:		termined (Sp	ecify) Major	Road / F	łighway	/				Route 491	@ Plea	sant Valley In	ntersection, Smithsburg,
Hosp 24 ho Fune tely f	a C	29a. Certifier 1 Certifying	Physician: To th	e best of my kr	nowledge, d	eath occu	rred at the	time, da	ite and pla	ice, and	due to the	cause(s)	and manner as	stated.
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certify the Funeral Director: After this certificate has been signed by the attending To the Funeral Director: After this certificate has been signed by the attending to the propriety filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only one) 2 Medical Ex	aminer:On the b	asis of examination	ation and/or	investiga	ition, in my	opinion,	, death oc	curred a	t the time, d			
	B e	29b. Signature and title of certi					29c	License	e number			1		(Month, Day, Year)
WA		10/111	110	1	1			0.0.1	M.E.			Au	ugust 14, 20	109
5		30. Name and address of person	on who completed	cause of deat	h (Item 23a	1								
9		Zabiullah Ali, M.D.	Assistant M				nn Stree		imore, l	MD 21	201			
	tate	31. Date filed (Month, Day, Yea.		32. Registrar's		16.	edd							
Regi		I ATTE	7 2000	Denoond.	v 13.	100	Charles							

CH5

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Division of Vital Records,

te filed (Month, Day, Year) AUG 04 2009

Canine

MO 900 Bestgate Road #300, Annapolis MD 2149
32. Pegistra's Signature
Anna S. Jane

werns M

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

werner,

Registrar

	1 - For State of Mai	ryland / Department of Health and I Certificate of Death	Mental Hygiene Reg. No. 2009 27410
Physiciar		ime	2. Date of Death Month Day Year August 9, 2009 3. Time of Death 8:22 a
/Medica Examine		4b. City, Town, or Location of Death Taneytown	
Funeral Director		(In yrs. last birthday) 76 Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Sep 11, 1932 Mary Land
Maryland -f show		10c. City, Town or Location Taneyto	10d. Inside City Limits wn 1 □ Yes 🌠 No
with the Mar a or 28a-f sl		10f. Zip Code 21787	10g. Citizen of What Country? USA
5-UU.30 72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examination to a codified at	11. Marital Status 12. Was Decedent Ev Armed Forces? 1 □ Never Married 2 Married 1 □ Yes 2 Mar	ver in U.S. 13. Was Decedent of Hispanic Origin? (S	pecify Yes or No- p Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: white
Z1Z15-UU36 ed within 72 hours aff ygiene. er than "natural", or er than "natural", or	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of wor	
D ∰± to b	17. Father's Name (First, Middle, Last)	'l'eacher 18. Mother's Nan	School ne (First, Middle, Maiden Surname) el Gladhill
VIATYIAN 12 Should be h and Mental 71s marked of traumatic ev	George Washington Shriner 19a. Informant's Name/Relationship (Type. Print) Donald Ray Warehime, husbar	19b. Mailing Address (Street and Number or Ru	ral Route Number, City or Town, State, Zip Code)
baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 is marked any Injury or other traumatic ex once.	20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	20b. Place of Disposition (Name of Scenetary, crematory or other place)	Date 20c. Location - City or Town, State /2009 Winfield, MD
baltimor permit. Pages Department of Important: If it any Injury or o	21. Signature of Funeral Service Licensee	22. Name and Address of Facility M	yers-Durboraw Funeral Home t, Taneytown, MD 21787
Physician /Medical Examiner		he death. Do not enter the mode of dying, such as cardiaconsequence of):	Interval Between Onset and Death
		consequence of):	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Madrical Certification: To Be Completed by Dhusician Madrical Examin		☐ Fetal death 3 ☐ Ectopic pregnancy	23d. Date of delivery Month Day Year
law requires that as been signed to 2 should be detailed by Detail	r art in. Other significant conditions contributing to death but	not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 ❷ No 3 □ Probably 4 □ Unknown
The law required to the second cate has been so the second cate has been			24a. Was an autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No
VILCA siclan: certific lirector,	25. Was case referred to medical examiner?	O44	th (Check only one) ome 5☐ Residence 6 ☐ Other (Specify)
LIVISION OF tall or Attending Physics after death. al Director: After this led in by the funeral differential of the funeral differential or the funeral differential differe		Year) 28b. Time of 28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how injury occurred
ital or Att urs after de ral Directe			28f. Location (Street and Number or Rural Route Number, City or Town, State)
the Hosp Ithin 24 hou the Fune Impletely fil	29a. Certifier (Check only one) 1 ▶ Certifying Physician: To the best of 2 ■ Medical Examiner: On the basis of and manner state	my knowledge, death occurred at the time, date and place examination and/or investigation, in my opinion, death occu- ed.	
To t To t com	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year) 8 10 2009
WHO	30. Name and address of person who completed cause of dea	TI ITERATION	St. TANGUTAN, mg 21787
State Registrar	31. Date filed (Month, Day, Year) AUG 1 1 2009 Services	s Signature B. Sparks	

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 a or 28a-f show any injury or other traumatic event, if a Practical Exmit an institute to notified at any injury or other traumatic event, if a Practical Exmit an institute to notified at any injury or other traumatic event, if a Practical Exmit any injury or other traumatic event, if a practical Exmit any injury or other traumatic event, if a practical Exmit any injury or other traumatic event, if a practical Exmit any injury or other traumatic event, if a practical Exmit any injury or other traumatic event, if a practical Exmit any injury or other traumatic event, if a practical Exmit any injury or other traumatic event, if a practical Exmit any injury or other traumatic event, if a practical Exmit any injury or other traumatic event, if a practical Exmit and injury or other traumatic event, if a practical Exmit any injury or other traumatic event, if a practical Exmit any injury or other traumatic event, if a practical Exmit any injury or other traumatic event, if a practical Exmit any injury or other traumatic event, if a practical Exmit any injury or other traumatic event, if a practical Exmit any injury or other traumatic event, if a practical Exmit any injury or other traumatic event, if a practical Exmit any injury or other event, if a practical Exmit and its angle in the event and its angle injury or other event, if a practical Exmit any injury or other event and its angle injury or other event and its and its angle injury or Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Sta

_	1 - For State Registrar	State of Mar	yland / Depa <i>Ce</i>	ariment of n rtificate of L			ene g. No. ? A A C	0 71	veet.
	Decedent's Name (First, Middle,	Last)				2. Date of Death		3. Time of	Death
in	Alice A. Wood					Month August 1	11, 2009 Year	5:50	P
al er	4a. Facility Name (If not institution,	give street and number)		4b. City, Town, or			4c. County of Dea		
	Hill Haven Nur	sing Home		A	delphi.		Prince (George's	
	5. Social Security Number 6		In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) C	irthplace (State or	r Forei
	214-30-1012	1 □ M 2 🖾 F	76 Yrs.	World Days	Tiodio IVIII.	September	6,1932 Ma	aryland	
	Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or Lo	ocation				10d. Inside Cit	v Limit
ō			Bowie					1 X Yes	
Director	Maryland Prince	George's	DOWLE	10f. Zip Code		10	g. Citizen of What C	ountry?	
	7105 Westwind	Drive		,	715		USA	,	
Funeral	11. Marital Status	12. Was Decedent Eve	er in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba		cify Yes or No-	14. Race - Am	nerican Indian,	
	1 ☐ Never Married 2 ☐ Marrie	Armed Forces? d 1 ☐ Yes 2 🔀 No	1			lican, etc.)	Black, Whi		
þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No	Specify:		Specify: W	hite	
Completed	15. Decedent's (Specify only highest	Education grade completed)		dent's Usual Occupa		11	6b. Kind of Business	s/Industry	
Id III	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired,)			e of Morr	-1
	12		Secret	ary to the	18. Mother's Name		niversity	OI Mary	/ Lai
Be	17. Father's Name (First, Middle, La William A. Dee	*.			Margaret		,		
မ					_	<u>_</u>			
	19a. Informant's Name/Relationship			ng Address (<i>Street a</i> Westwind			City or Town, State,	Zip Code)	
	Thomas R. Dwye						0c. Location - City o	r Town State	
	1 ☑ Burial 2 ☐ Cremation 3	I — nemovariiom state		osition (Name of matory or other place oln Cemetery			rentwood,		d
	4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Like			2. Name and Addres		2009 B	Tentwood,	- Maiyian	
	21. Signature of Fulleral Service Lik	RAL Roger			-	. D A I	4739 Balt: Hyattsvil:	imore Av	enu
	23a. Part1. Inter the dis see, or conshock, or heart failure. List or	omplications that caused the						Approximate Interval Betv Onset and D	e ween
	Immediate Cause (Final disease or condition resulting in death)	a. Clostridi	lum Diffi	cile Coli	is				
		Due to (or as a c	onsequence of):						
ē	Sequentially list conditions,	b Due to (or as a c	onsequence of):						
E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
Examine	that initiated events resulting in death) Last	c Due to (or as a c	onsequence of):						
ca		- d					1		
		d							
	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		Testonia pragnancia			23d. Date of de	elivery	
	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tir	Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of de Month	*	/ear
	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal death 3 [ne of death 5 [Other (specify)				*	'ear
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State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar		,	Ce	rtificate	of De	eath		Reg. No.	2009	271	20
	Physici	an	1. Decedent's Name (First, Middle	e, Last)						2. Date of Di Month	eath Day	Year	3. Time of I	
	/Medic		James Lee							7	31	2009	3:35	РМ
	Examin	er	4a. Facility Name (If not institution				4b. City, To	own, or Lo	cation of Death			County of Death		
			Bowie Healthca 5. Social Security Number		e (In ure le	ast birthday)	Bow If Under 1		Under 24 Hrs.	8. Date of B		Prince G		Foreign
	Funeral Director		579-50-9979 Usual Residence of Decedent	1⊠ M 2□ F	6	Van			Hours Min.	(Month, D	<i>Day, Year)</i>		nplace (State or intry) ington,	
	land ow		10a. State 10b. County		10c. City	, Town or Lo	ocation						10d. Inside Cit	y Limits
	Mary -f sh	ţ	DC		Wasi	hingto	nn.						1 🖺 Yes	2 □ No
	h the	Director	10e. Street and Number		(Nasi	IIII CC	10f, Zip C	Code			10g. Citi	zen of What Cou	intry?	
	th wit		3416 Baker Str	eet. NE			2	0019			υ	SA		
	ems	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	13.	Was Decede	nt of Hispa y Cuban, N	anic Origin? (Sp Mexican, Puerto	ecify Yes or N Rican, etc.)	lo-	14. Race - Amer Black, White		
21215-0036	within 72 hours after death with the Maryland giene. r than "natural", or items 23a or 28a-f show the Medical Exar iner roust Le nollified at	þ	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 💆 Divorced	ried 1 Yes 2	No		1 □ Yes 2 1					Specify:	ack	
5-0	72 ho 'natu	etec	15. Deceden	t's Education st grade completed)		(Give	dent's Usual kind of work	done duri	on ing most of work	ing	16b. Kir	nd of Business/I	ndustry	
121	within iene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)	`life.	DO NOT use	retired)		_	١.		1.0	
2	illed wall Hygie other t		17. Father's Name (First, Middle,	(4 () () () () () () () () ()		Disas	ster R		Specia B. Mother's Nam			rican R	ed Cros	S
Maryland	should be fi and Mental I s marked of umatic eve	Be							Ora McK		0, 111010011	o a marrio,		
<u> </u>	2 should and Me is mark aumati	2	James Lee With			19b. Mailii	na Address (ber. City o	r Town, State, Z	ip Code)	
	s 1 and 2 should be filed of Health and Mental Hyg item 27 is marked othe other traumatic event,		Patricia Marti				Pearti					e, MD 20		03
ē,	s1a ofHe∉ item othe		20a. Method of Disposition		20b. Pl		osition (Name matory or oth			Date		cation - City or T		
E	Page nent c int: If		1 ☐ Burial 2 🖾 Cremation 4 ☐ Donation 5 ☐ Other (S		1				ry 8/11	/2009	Bre	ntwood,	MD	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra once.		21. Signature of Funeral Service	Licensee	.0							neral H		ıc.
<u>m</u>	8 8 5 5		Joseph Monta	oney-Chea	Han	- 3	401 B1	adens	sburg R	oad Br	entwo	ood, MD	20722	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each li	the death.	. Do not en	ter the mode	of dying, s	such as cardiac	or respiratory	arrest,		Approximate Interval Bety	veen
12	Physician		Immediate Cause (Final disease or condition	- CEREB	ROV,	ASCH	LAR	A	CCIDE	VI			Onset and D	/eatti
	/Medical Examiner		resulting in death)	Due to (or as										
	=xa	<u>.</u>	Sequentially list conditions,	b. Hy P			NG							
	nsit	Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1 T 11	·	•	FRAC							
	execu n and al-tra	Exal	that initiated events resulting in death) Last	c. Due to (or as	a consequ	ence of):	É Ros	1>						
68760	rtificate be executed ng physician and as the burial-transit			d.										
	ertifica ling phi e as th	Medical												
Вох	S di se		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			☐ Ectopic pre	anancy			1	23d. Date of deli	-	
P.O. B	w requires that the death oc been signed by the attend should be detached for use	Physician/	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant a			Other (spe					Month	Day Y	'ear
ώ. σ	s that ned b		Part II. Other significant condition	ons contributing to death b	ut not resul	iting in the u	nderlying cau	use given i	in Part I.	23e. Did	l tobacco u	se contribute to	the cause of d	eath?
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ecc	e law re has be je 2 sho	Completed by								24a. Wa	s an opsy	24b. Were au	topsy findings a	available ause of
<u>~</u>	The ate h page	ĕ								per	formed? 2 🖸 No	death?	2 □ No	
/ita	cian: ertific	Be (25. Was case referred to medical examiner?					1	6. Place of Dea				110014	
of \	Physical this call dire		1 ☐ Yes 2 ☐ No				nt 3 DOA					3 X Other (Spec	Healt Cente	r
n	ding I	jou	27. Manner of Death 1 Natural 5 □ Pendin	28a. Date of Inju (Month, Da		28b. Time o Injury	т 286 М	c. Injury at Work?		28d. Describe	e how injur	y occurred		
<u>Si</u>	death ctor: / the	icat	2 Accident investigned investigned a Suicide 6 Could	not ho	ury - At hor	me farm str			s 2 □No	28f Location	(Street an	d Number or Ru	ıral Boute Num	her.
Division of Vital Records,	al or A s after il Direct	Certification: To	4 ☐ Homicide determ	ined 28e. Place of Inj building, et	c. (Specify)	oct, laotory, t	omee		City or To	own, State)	ra riodio ivali.	501,
	To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for u	Medical (ng Physician: To the best Examiner: On the basis of and manner st	f examinati)
	To the I within 2 To the I complet	Me	29b. Signature and title of certifie	r V			29c.	License n	umber		29d. Dat	te signed (Montl	n, Day, Year)	
			•	Jun -			2	310	6			Z	13/09	
	7		30. Name and address of person	who completed cause of c	leath (Item	23a) (Type,	1 22	J					1-1-1	
<u> 1</u> 4			ALADDIN B	OLAD 1	0 11	vina	st	Mh) W	oshing	tm	DC	20010	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registr	ar's Signati	LIFO-	,			1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Months 1930 P M AALSBURG WIESSNER COLLEEN 03 2009 4b. City, Town, or Location of Death County of Death Facility Name (If not institution, give street and number) If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday Days 1 □ M 2 1 F Months Hours Min. 954 GRAND RAPIDS MI 372-50-3911 06 Usual Residence of Decedent 10b. County 10c, City. Town or Location 10d. Inside City Limits 1 XYes 2 □ No RALEIGH WAKE 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number 2144 RAMSGATE USA STREET 27603 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐Yes 2 No Specify: If Yes, Give Year or Dates: Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) PROFESSOR 18. Mother's Name (First, Middle, Maiden Surname) MARGARET JUNE STRUIK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2144 RAMSGATE WIESSNER RALEIGH, NC 27603 ALLEN

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy hjury or other traumatic event, it is Madical Evarrine must be notified an ans.

Physician

Examiner

Funeral

Director

/Medical

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Director

Funeral

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Physician /Medical **Examiner**

Baltimore, Maryland 21215-0036

Box 68760

burial-tran the. attending p for use as t signed by the a detached f cate has been signaled by funeral director, After this the

Hospital or Attending Physician: The law requires that the death certificate be executed To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Af filled in by completely

Division of Vital Records, P.O. State Registrar

Completed Elementary/Secondary (0-12) NC STATE UNIVERSITY 12 17. Father's Name (First, Middle, Last) Be JOSEPH THEODORE ARLSBURG 19a. Informant's Name/Relationship (Type. Print) ST. CHARLES 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SALISBURY CREMATORY 8-7-09 SALISBURY, MD. 22. Name and Address of Facility
HOLLOWAY FUNERAL HOME PA Signal re of Funeral Service Licensee RD. dompson CFSP SALISBURY, MD. 501 SNOW HILL 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOCARDIAL disease or condition resulting in death) INFARCTION Due to (or as a consequence of): ASCVD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to forces a consequence offi-Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ğ MORBID OBES IT) 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 🔲 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 25 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 48098 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HALL HIGHWAY, CRISFIELD, MD, 21817 · VIJAY KARUMBUNATHAN 201. 32. Registrar's Signature 31. Date filed (Month

Unpend 23a,27, & Zoa-1, per ME G896 10/1/09 TT Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** М ALBERT ALSTON 2009 AUG 1634 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2943-A PIERCE COURT FORT MEADE MD ANNE ARUNDEL Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 X M 2 □ F Director 03-01-1953 Maryland 214-58-6400 56 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show ed other than "natural", or items 23a or 28a-f shovevent, The Westled at 1X Yes 2 □ No Director Fort Meade MD Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code items 23a 2943-A Pierce Court 20755 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ð 3 ☐ Widowed 4 ☐ Divorced black. Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) U. S. Government Human Resource Specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mattie Stuckey 2 Ben Alston, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Kristine Alston / Wife 422 Seeling Blvd. San Antonio, Texas 78228 permit. Pages 1 and Department of Healt Important: If Item 2: any injury or other it 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) MD. Veterans Cemetery 08-28-2009 Crownsville, Maryland 21. Sign One of Juneral Service Linens 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A 1411 Annapolis Road Odenton, Maryland 21113 Part 1 Striter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** Undetermined /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and physician a s the burial-Due to (or as a consequence of) Box 68760, certificate be Physician/Medical the attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 2 □ No 1 Yes the o 9 Unknown 9 Unknown þ σ, signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼ No 24a. Was an autopsy performed? Yes 2 \(\square\) No The page certificate 1X Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Pesidence} \) 6 \(\text{Other} \(\text{(Specify)} \) 1√2 Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred or Attending 1 ☐ Natural death. 08/12/2009 1 ☐ Yes 2 ▼ No 1634 unk Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Boute Number City or Town, State) 2943-A Pierce Court 4 Homicide hours after home hin 24 hours at the Funeral D Fort MEade, MD Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature a 10 title of certifier 227359 (NY) of death (Item 23a) (Type, Print) 30. Name and address of person who complete ed c ARMED FORCES INSTITUTE OF PATHOLOGY MC USAF DZUY NGUYEN LtCo1 ROCKVILLE MD 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 27 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Year 08:42PM 08 22 2009 /Medical Thomas Richard Adkins 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner <u>Union Memorial Hospita</u> Baltimore Funder 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 ☐ F Months Days Hours Min. 72 5, 233-<u>58-3608</u> West Virginia Director 1937 Aug. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show 10b. County item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Madical Examinat rayst be notified at 1 XYes 2 No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2615 Miles Avenue 21211 United States Funeral 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 250No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify Specify: White <u>۾</u> 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 7 years <u>Auto Mechanic</u> Auto 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fi h and Mental F 7 is marked ott James Adkins Elsie Gil 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health an Important: If item 27 is r Stella Adkins (Wife) 2615 Miles Avenue Baltimore, Maryland 21211 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ō 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from Ş Injury Donation 5 ☐ Other (Specify) ewicklev Cemetery 8/28/2009 Sewickley, Pa. Funeral Arvice ignatu 22. Name and Address of Facility anyl Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222
ath. Do not enter the mode of dying, such as cardiac or respiratory arrest,
Approxim Part 1. Enter the disease, or complications that caused the d shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 3 days Ciastrointestinel resulting in death) /Medical Due to (or as a consequence of): Examiner Duase Amonuc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the death certificate be executed Mass attending physician and for use as the burial-tran Due to (or as a consequence of): O. Box 68760. nsease Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) ☐Yes 2☐No been signed by the should be detached 9 Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 🗌 Yes 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐Yes 2 ☐ No 1 ☐Yes 2 🗸 Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending death. nours after death.

neral Director: / 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 472438446

State Registrar

DHMH 17 Rev 1/2001

WION MEMOPIAL HOSPITAL BALTIMORE, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Degistrar's Signature

KHAT KAR,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. d 20b-c perFh G894 8/27/09 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 0 **Physician** CHAUNCEY 030UM BUDD /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Tate Hospice House Lithicum | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 06-25-1959 9. Birthplace (State or Foreign Country)
Wash. DC 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☑ M 2 ☐ F 579-86-7981 50 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The Medical Examiner must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Upper Marlboro PG MD 1X Yes 2 □ No **Funeral Director** 10f. Zip Code 20774 10g. Citizen of What Country? 10e. Street and Number 1211 Canvasback Ct. USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc ☐Yes 2 Yes, Give X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify: Black ģ 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Chef 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Allen Elizabeth Budd Jean ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 19a. Informant's Name/Relationship (Type. Print)
Regina Wingfield/ Sister 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State valdorf, MD BAItim<u>ore,</u>MD 08-29-09 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityRonald Taylor II FH 21. Signature of Funeral Service Licensee 10583 Middleport Ln. White Plains, MD 20695 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Hospital or Attending Physician: The law requires that the death certificate be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes 2 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred HUISE 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) Signature and title of centifier 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) EFFWSE altN 32. Registrar's Signature State

Registrar

eorge Charles l		- For State	Sta	te of Marylar	nd / Depart <i>Certit</i>	ment of ficate of	Health and Death	Mental	Hygiene	Reg. No.	20	19 276
Physicia	R	egistrar . Decedent's Name (I	First, Middle,	Last)					2. Date of D Month	eath Day	Year	3. Time of Death 1858 hrs
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,	4	a. Facility Name (if n			nber)	4	b. City, Town, or I Catonsville	ocation of D	eath		Baltimore Co	
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filted within 72 hours after death with the Maryland Department of Health and Mental Hyggine. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Numb 6340 Fred		Road, Apa	artment !	В	10f. Zip Code 21228	,			ited Sta	
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21 should ond Mer is man	ဥ	19a. Informant's Nan		hip (Type, Print) Jr./Fathe:	r	1267	Weller W	lav. W	estminst	er, l	Maryland	1 21158
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	Me /	IF FEMALE: 23b. Was decedent	pregnant in t	h -	outcome of pregr		etal death 3	Ectopic	pregnancy		23d. Date of del	Day Year
68 certifi	cian	past 12 months	?		nant at time of de		other (Specify)		,			
Box e death c the atten	Physician/Me	1 Yes 2		nknown g Unkr					220	Did tobac	co use contribu	te to the cause of death?
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S, P, nires th signe d be d	l be									Was an	24b. Wei	re autopsy findings availa
ords w requas been	bet	,							_	autopsy performe	ed? dea	
of Vital Records, ig Physician: The law requin ther this certificate has been simeral director, page 2 should be	Completed									Yes 2	_No 1 ✓	Yes 2 No
tal Rec	BB	25. Was case refer examiner?	red to medic	Hospital:		ER/Outpatie		Other	(Check only one) Nursing Home	5 Re	esidence 6	Other: Scene
F VII	ا ا	1 ✓ Yes 27. Manner of Deat	2 No	28a. Dat	Inpatient 2	28b. Time of		njury at Work			w injury occurred	
n of \ Iding Phy h. After tl		1 Natural		(Mon	th, Day, Year) 3/22/09	Fd 7:3	39 pm 1	Yes 2X				
Division is after death.	cat	2 Accident	6 X Co	estigation	ace of injury - At h	ome, farm, st		e building, et	tc. 28f. Loc	ation (Stre	eet and Number	or Rural Route Number, rederick Rd
Div ital or ital or rat Dir ited in	Certification:	3 Suicide 4 Homicide	det	ermined (Specifi					Apt	B Ba	ltimore	, MD
Division of Vital Records, P.O. Box 6876C To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physomolecky effled in which findent director, page 2 should be detached for use as the b		29a Certifier	Certifying	Physician: To the b	est of my knowled	dge, death oc	curred at the time,	date and pla	ace, and due to the ccurred at the time	e cause(s	s) and manner as d place, and due	s stated. e to the cause(s)
To the Hos within 24 h To the Fur	Medical			and mainter	stated.	and/or myesu		ense number		12	29d. Date signed	(Month, Day, Year)
	Σ	29b. Signature and	title of certi	nier	0			C.M.E.			August 23, 2	2009
		Monje	not V	on who completed ca	use of death (Iter	m 23a)		-				
J		30. Name and add Margarita K			edical Exami	ner 111	Penn Street,	Baltimore	e, MD 21201			
(i	State				Fegistrar's Signa	ture						
Reg			UG 2	7-2000 /	marin ,	a. Jak	What					
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			For State Registrar	State of N	Maryland	•	artment			and Me		iene eg. No. 🤈	nno	271.25
		•	Decedent's Name (First, Middle, L.)							2	. Date of Deat	h (3. Time of Death
	Physici		James	Busey	Ben:	nett	<u> </u>				Month AUG	Day 2 3	Year 2009	06:45 M
al King	/Medi Examir		4a. Facility Name (If not institution, ga					Fown, or	Location o	of Death			nty of Death	
			Howard Con	nty Husp	retal		Co	-au	mbi	a		He	guan	$d \cdot$
	Funeral Director			Sex 0 1. 1 ☑ M 2 □ F	Age (<i>In yr</i> s. <i>I</i> a 86		If Under Months	1 Year Days	If Under Hours	24 Hrs. 8 Min.	Date of Birth (Month, Day, June 3,	Year) 1923	9. Birth Cou Mary	place (State or Foreign ntry) r land
	pu >		Usual Residence of Decedent 10a, State 10b, County		100 City	Town or Lo	antion							10d. Inside City Limits
	e Maryia 3a-f sho v Illfod at	ctor	MD Howa	rd	Toc. City,		licot	t Ci	ty					1 ☐ Yes 2 ☑ No
	th with th	Funeral Director	10e. Street and Number 4053 Jay Em				10f. Zip	Code	2104	42	1	0g. Citizen o Ur		ntry? States
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marical Evaluir or must be 10 citied at once.	by Funer	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decede Armed Force 1 [7] Yes 2 [If Yes, Give Year or Date	s? No		Was Deced If Yes, spec 1 □Yes 2		spanic Ori n, Mexicar Specify:	gin? (Specii n, Puerto Rid	fy Yes or No- can, etc.)		lace - Ameri lack, White, cify:	
215-0	hin 72 ho 9. an "natur Medical J	Completed by	15. Decedent's E (Specify only highest g	ducation rade completed) College (1-4d	or 5+)	16a. Dece (Give life.	dent's Usua kind of wor DO NOT us	l Occupa k done d e retired,	ation <i>Juring mos</i> i)	t of working		16b. Kind of	Business/Ir	ndustry
21,	d with giene er the	E C	Elementary/Secondary (0-12)	College (1 40	,, 51,		Carpe	nter	•			Cor	nstruc	tion
5	e file al Hy d othe	Be	17. Father's Name (First, Middle, Las							,	First, Middle, I		ame)	
yla	Ment Ment arkec	ဥ	Rufus Bennet	t 					Lil	lian I	rene B	usey		
Baltimore, Maryland 2121	und 2 sho alth and 127 is m er traum		19a. Informant's Name/Relationship Joan Bennett (W				ng Address Jay				Route Number City,	-		p Code)
ore.	of He fiter	-	20a. Method of Disposition	70	20b. Pla	ace of Dispo	sition (Nam	e of her place	e)	Date	е	20c. Location	n - City or T	own, State
Ĕ	Page ment ant: I		1 ☐ Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Spec							8/27/	′09	E1krid	ige, M	aryland
Balt	permit. Departimport any inj		21. Signature of Funeral Service Lice	ensee	1/	- G	ary L	Addres Ka	s of Facilit ufmar	Fune	eral Ho	me at	MMP,	Inc.
	Physician /Medical		23a. Part 1. Enter the disease, or cor shock, or hear failure. List only Immediate Cause (Final disease or condition resulting in death)	_a	EPSIS	Do not ent	er the mode	of dying	g, such as	cardiac or r	espiratory arr	est,	. 110 2	Approximate Interval Between Onset and Death 5 - 7 days
7%	Examiner	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		as a conseque as a conseque as a conseque as a conseque		rearl		cul	ne	,			5-7 days
O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	me of pregnan h 2 □ Fetal o	cy death 3[⊒ Ectopic pr ⊒ Other <i>(sp</i> e	egnancy				1	Date of delive	very Day Year
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ita	ian: rtifica stor, p	Be C	25. Was case referred to medical						26. Place	of Death (1 □Yes Check only on		1 1 1 1 1 1 1 1	2 1110
>	nysic lis ce direc	5 B	examiner? 1 ☐ Yes 2 Ø No	Hospital: 1 1/2 Inpa	atient 2 🗌 E	R/Outpatier	nt 3 🗆 DO	A Othe	er: 4 🗆 Nu	ursing Home	5 🗆 Reside	ence 6 🗆 0	Other (Spec	ify)
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Division	tal or Atters after dea al Directored in by the	Certification:	3 Suicide 6 Could not 4 Homicide determined	28e. Place of	Injury - At hon etc. (Specify)	ne, farm, str	eet, factory,	office		281	f. Location (Si City or Town	treet and Nui n, State)	mber or Rui	ral Route Number,
	he Hospi in 24 hou he Funer pletely fill	Medical		hysician: To the be miner: On the basi and manner	s of examination									
	To t with To t	Σ	29b. Signature and title of certifier	SV	~		290	License	number	1371	2	9d. Date sig Auf		, Day, Year) 2009.
	6+1		30. Name and address of person who	completed cause of	of death (Item :	23a) (Type,	Print)	Col	lum	bia	, MZ			
1	Sta	te	31. Date filed (Month, Day, Year)	32. Regi	tràr's Signatu	ire /	how	1					•	

Amend #30 per DVR g894 8/2//09 TT State of Marward Pepagtment of Health and Mental Hygiene Certificate of Death

Reg. No. 200 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician GEORGE WASHINGTON BARRETT, JR. **AUGUST** 10:30P ^M 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4122 Kahlston Rd. Baltimore Perry Hall 8. Date of Birth (Month, Day, Year)
July 25,1921 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1**X** M 2 □ F 219~07~0855 88 Maryland Director Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location , or items 23a or 28a-f show 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Baltimore Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4122 Kahlston Rd. 21236 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1XXX'es 2 □ No If Yes, Give Year or Dates: WW 1 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 21215-0036 Specify.White 1 ☐ Yes 2XXNo Specify: ed other than "natural", o \$ WW 11 3 Midowed 4 □ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)

Past President/Senior Rosedale Federal Elementary/Secondary (0-12) 12 yrs. College (1-4or 5+) Savings & Loan, Assn. Executive VP permit. Pages 1 and 2 should be filed.
Department of Health and Mental Hygi
Important: If item 27 is marked other
any Injury or other traumatic event, II Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Washington Barrett, Sr. Stella Briddell 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy Stinemire (Daughter) 2111 Laurel Brook Rd. Fallston. Md. 21047 20a. Method of Disposition

Y

Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Lorraine Pk. Cemetery 9-4-2009 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) olgrature of Funeral Service Licensee 22. Name and Address of Facility
Lassahn Funeral Home 7401 Belair Rd. Md. 21236 Balto.. MX 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 5 qua mous disease or condition resulting in death) /Medical Due to (or as vonsequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ned by the a detached f 1 ☐ Yes 2 ☐ No. 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à ecunouiti 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy performed? Yes 2 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 4 \(\superstruct{\substraction}{\substraction}\) Nursing Home Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 ☐ Accident 1 ☐ Yes 2 No within 24 hours after deatl To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title 20034650 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeffrey ALan Cool, MD5009 Honeygo Center, Suite 216 Perry Hall, MD 21128 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Approximate Interval Between Onset and Death

Month

Day

Year

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 s Department of Health ar. Important: If item 27 is any Injury or other traus

Physician

Examiner

Director

Funeral

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Funeral

Director

/Medical

Physician /Medical Examiner

Box 68760

physician and s the burial-trans

Completed Elementary/Secondary (0-12) Forklift Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Delita Lettsome Austin Blyden ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Austin Henry Blyden/ brother 7200 Carroll Ave., Takoma Park, MD 20912 20c. Location - City or Town, State USVT 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Sept. Date 3, 1 ☐ Burial 2 ☐ Cremation 3 🖾 Removal from State Smithbay, St. Thomas, Eastern Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2009 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee Ken Kele M01053 313 Talbott Ave., Laurel, MD 20707 land. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final a HotenioscleroTie disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. Was an autopsy performed? 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only ope) examiner? 1⊿ Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 | Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c, License number

the Hospital or Attending Physiclan: The law requires that the death certificate be executed P.O. I s been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ binknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No Vital 2 🖃 No 1 ☐ Yes Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To Division of this 28d. Describe how injury occurred After hours after death. 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (VAde 3001 31. Date filed (Month, Day, Year) egistrar's Signature State AUG Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

			For	State of Ma	ırylan					and M	ental Hy	giene		071	. 20
	_		State Registrar 1. Decedent's Name (First, Middle, La	n#l		Cei	rtificat	e of L	eath		2. Date of De	Reg. No	2003	3. Time of	of Dooth
	Physicia /Medic		,	BROWNE,	//ek	2					Month 08	24	Year	11.0	S/PM
5	Examin		4a. Facility Name (If not institution, give	1 / 11		0	4b. City,	\sim 1	Location o			4c.	County of Dea	th	
and t			5. Social Security Number 6. S		Pit	last birthday)	If Under		If Under 2		8. Date of Bir	N,		thplace (State	or Foreian
	Funeral Director			I M 2 1 F 7. Age		6 Yrs.	Months		Hours	Min.	(Month, Da	y, Year)	C	ountry)	MD
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside 0	City Limits
	be filed within 72 hours after death with the Maryland ntal Hygiene. 3d other than "natural", or items 23a or 28a-f show event, the Medical Evariner must be notified at	tor	MD N/A											1 😿 Ye :	s 2□No
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	er der items	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		S. 13.	Was Dece If Yes, spe	dent of Hi cify Cuba	spanic Orig n, Mexican	gin? (Spe ı, Puerto F	cify Yes or No Rican, etc.)	-	14. Race - Am Black, Whi		
036	urs aff al", or Erani	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🙀 Divorced	1 □Yes 2 ★ If Yes, Give Year or Dates:			1 □ Yes	² XNo	Specify:				Specify:	WHITE	
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ylar	should be filed withir and Mental Hygiene. s marked other than umatic event, the M	70 E	LAWRENCE KNAPP						MAR	Y EST	THER BA	RBEI	R		
Maryland	2 s lar		19a. Informant's Name/Relationship (MICHELE BROOKS-DA					,				-	or Town, State,		
e,	1 and Health tem 27 other to		20a. Method of Disposition	AUGHIEK	20b. F	Place of Dispo emetery, crer			MILL		ate DAL		ORE, MD		
٥	Pages nent of int: If its iry or o		1 Burial 2 Cremation 3 □ 4 Donation 5 Other (Specia			emetery, crer ARDENS			<i>∍)</i> ¦	g / 2°	7/09	RΛT	LTIMORE	MD	
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<u>=</u>	nysici	lo Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatie	nt 2 🗆	ER/Outpatier	nt 3 🗆 D	OA Othe	· · ·			·	6 ☐ Other (Sp	ecify)	
0	ing PI	:uo	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y , Year)	28b. Time of Injury		28c. Injury Work			8d. Describe	how inju	ry occurred		
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 Hours are redeath. Within 24 Hours are Indeath. To the Funeral Director After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical ((Check only 2 Medical Exa	hysician: To the best of miner: On the basis of	examina	wledge, deat	h occurred	at the tin	ne, date an pinion, dea	nd place, a	and due to the	cause(s date an	s) and manner d place, and du	as stated. le to the cause	(s)
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			30. Name and address of person who	completed cause of de	eath (Iten	n 23a) (Type,	Print)	61	0 0				100	1200	
	(h di	Ignis Bumber	completed cause of de 2, 5600 32. Pégistre	Loc	4 K91	ieh 1	5/10	1, B	al7	MORE	, /	10,2	1237	/
	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 7 2	109 Sz. Hegistra	u s signa	A. A	ark	A. C.							

			1 - For State Registrar	State of M	aryland		artment rtificate			nd Me	-	gien Reg. N	000	10	27	430
	Physici: /Medic		1. Decedent's Name (First, Middle, Last)	Larry	Ray	F	Brown				2. Date of De Month August	D	ay 4, 20	Year	3. Time 9:55	of Death
Examiner 4a. Facili			4a. Facility Name (If not institution, give s 247 Trappe Road	treet and number,	number) 4t			4b. City, Town, or Location of Death Dundalk					4c. County of Dea			
I	Funeral Director		5. Social Security Number 6. Sex 212-46-8663 1 ☑	M 2□ F 6		ast birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hours	Min.	B. Date of Birl (Month, Da Jan。 1	y, Year	r)	9. Birthp	place (State	or Foreign
	ath with the Maryland 23a or 28a-f show ust be notified at	ral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Balti 10e. Street and Number 247 Trappe Road	more	, Town or Lo	Dundalk 10f. Zip Code 21222				10g. Citizen of What			hat Cour	10d. Inside City Limits 1 □ Yes 2 🗓 No Country? States		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, If a Mydical Exprintment rust be neithed at once.	Completed by Funeral I	1 Never Married 2 Married 3 Married 4 Divorced 15. Decedent's Educ (Specify only highest grade) Elementary/Secondary (0-12)	2. Was Decedent Armed Forces? 1 X Yes 2 ☐ If Yes, Give Year or Dates: ation completed)	No Vietna	am 16a. Decec (Give life. I	l □Yes 2 dent's Usua kind of work DO NOT use	No I Occupa k done di e retired)	Specify: tion uring most of	f working	ify Yes or No can, etc.)	16b.	Black Specify: Kind of Bus	white, white, which was a second with the seco	Mite dustry	
/land 2	uld be filed w Mental Hygie arked other t atic event, IL	To Be Co	9 Years 17. Father's Name (First, Middle, Last) Lawrence Brown			Ass	embly	- 1		Name (First, Middle, h Tuck	Maide		•	ors,	Corp.
	and 2 sho fealth and I m 27 Is ma her trauma		19a. Informant's Name/Relationship (Type Henry Sauer(Bro	,		1007	Ceda	r Cr		oad	Route Number	, M	aryla	nd	21221	
altimore,	t. Pages 1 tment of H tant: If Ite		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	0 0	ce	-	ervic	e Co	rp. 8,		2009	То		Mar	yland	ł
Ba	permi Depa Impo any ir		21. Signatur Funeral Service License 23a. Part 1. Enter the disease, or complice	Ken			<u> 7922 1</u>	Wise	Ave.	Dui	Home o	Ma:	undal rylan	k, I d 21	222	
	ticate be executed / Medical Examiner Examiner sthe burial-transit sthe burial-transit	al Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, reading to minieulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a conseque	ence of):	1	1	vØ () a, s	(ase		Approximatinterval Bronset and	etween d Death
. Box t	death certi le attending ld for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ic. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal of	death 3 □	Ectopic pre						23d. Date Mon		ery Day	Year
ecords, P	law requires that the as been signed by th 2 should be detache	P	Part II. Other significant conditions cont	ributing to death b	ut not result	ting in the ur	derlying ca	use giver	n in Part I.		23e. Did to			bute to th	ne cause of	death?
<u>r</u>	The la ate has bage 2	Completed									24a. Was autop perfor 1 □ Yes	SV	pr de	ior to co eath?	psy finding mpletion of	s available cause of
VItal	Physician; r this certific ral director, p	Be	25. Was case referred to medical examiner? Yes 2 □ No	ospital: 1 ☐ Inpatie				Othou			Check only o					
Ion of	nding Phy tth. ;; After this e funeral d	ation: To	27. Manner of Death 1*** Natural 5 Pending 2 Accident investigation	28b. Time of Injury	4 Nursing Home 5 K Residence					e 6 Other (Specify) njury occurred						
DIVISION	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Director.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At horr c. <i>(Specify)</i>	ne, farm, stre	et, factory,	office		28	f. Location (S City or Tow	Street a n, Stat	and Numbe te)	r or Rura	l Route Nu	mber,
	the Hospi lin 24 hou the Funer	Medical	29a. Certifier 1 ☐ Certifying Physic (Check only one) 1 ☐ Certifying Physic (Check only one)	cian: To the best er: On the basis o and manner st	f examination	rledge, death on and/or inv	occurred a restigation,	at the tim in my op	e, date and p inion, death o	place, ar occurred	d due to the at the time,	cause(date ar	s) and mar nd place, a	nner as s	tated. the cause	(s)
	vith To 1	≥	29b. Signature and title of certifier	ytuge			29c.	License	number	>			ate signed		Day, Year)	39
			30. Name and address of person who com	(o MD	eath (Item 2	23a) (Type, F	Print)	Ci	Lat	her	1/2	ary	95	109	3	
	Stat Registra	_	31. Date filed (Mon h, Day, Year) ALIG 9 7 2009	2. Registr	ar's Signatu	lire Ann	Lad .				7					

9-06660 ason Barley		Please Type or Print in Black Indelib State of Maryland / Departme			ibie.	00 071
Physicia Medical Exami	an/	Registrar 1. Decedent's Name (First, Middle,Last)	rley	2. Date of Death Month August 25,		3. Time of Death 1822 hrs
and the same of th		Facility Name (if not institution, give street and number) Mercy Hospital	4b. City, Town, or Location of Death Baltimore		4c. County of Deat	h
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthon 1219-13-9681 1X M 2 F 30 Usual Residence of Decedent	Ay) If Under 1 Year If Under 24Hr Months Days Hours Min	٦.	Co	rthplace (State or Foreign buntry) aryland
Maryland 28a-f show any d at once.	tor	10a. State 10b. County 10c. City, Town or Maryland Baltimore 10e. Street and Number	Location Dunda1k 10f. Zip Code	110	g. Citizen of What Cou	10d. Inside City Limits 1 Yes 2 X No
death with the Maryland or items 23s or 28a-f sho	Dire	1520 Leslie Road	21222 13. Was Decedent of Hispanic Origin? (S		United St	•
s after death v ral", or item	by Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 X No specify:		White, etc. Specify:	White
21215-0036 Uld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f she event, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	ecedent's Usual Occupation (Give kind of rring most of working life. DO NOT use re Lawn Service		16b. Kind of Business Lawn Mainten	
21215-0036 ould be filed within 7 if Mental Hygiene. s marked other than ie event, the Medica	8	17. Father's Name (First, Middle, Last) Jack K. Barley 19a. Informant's Name/Relationship (Type, Print) 19b.		e (First, Middle, M • Radako	vic	a Zin Cada)
e, MD 2 Land 2 shoul Health and N item 27 is n traumatic	To	Joy A. Barley (Mother) 1 20a. Method of Disposition 20b. Place of	520 Les1ie Road Disposition (Name of cemetery,			21222
Baltimore, MD 21215 permit. Pages and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked o injury or other traumatic event, th		I A bullar 2 Cremation 3 Removal nom State	y or other place) Lutheran Cem. 8/ 22. Name and Address of Facility Duda—Ruck Funeral	28/2009		e, Maryland
M 링스트로 Physician /Medical	-	23a. Part I. Enjoythe disease, or complications that caused the death. Do not failure. List only one cause on each line.	1/922 Wise Ave. Ditenter the mode of dying, such as cardiac	or respiratory arre	Maryland 2	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Acute heroin and on the properties of the conditions are consequence of the conditions.	alconol intoxicatio	on		
asit ed	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):				
60, Sate be executed hysician and e burial - transit	Medical	IF FEMALE: d. AMENDED 23a,2/,28a	-f,perME, g894 8/3	.709 TT	23d. Date of delive	ry
Division of Vital Records, P.O. Box 68760, to the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. For the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1	Fetal death 3 Ectopic pregr Other (Specify)	nancy	Month	Day Year
S, P.O. B uires that the d r signed by the	þ	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	1 Yes		obably 4 🗸 Unknown
Division of Vital Records, tal or Attending Physician: The law requirers after death. at Director: After this certificate has been sited in by the funeral director, page 2 should be	Completed			24a. Was a autop: perfor 1 Yes	sy prior to med? death?	
ing Physician: The fing Physician: The After this certificate uneral director, page	To Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No 1 Inpatient 2 ✓ ER/Out 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Ti	26.Place of Death (Checl patient 3 DOA Other Wars me of Injury 28c. Injury at Work?	ing Home 5	Residence 6 Oth	er:
Vision of or Attending Ph frer death. Director: After in by the funeral	Certification:	Pending Fd 8/25/09 Fd 5	5:55 pm 1 Yes 2 X No m, street, factory, office building, etc.	unk 28f. Location (S	Street and Number or F	Jural Route Number, City
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director:	Medical Cert	4 Homicide determined (Specify) 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or inv	n occurred at the time, date and place, an	baltimon	e(s) and manner as sta	ated.
To To To Com	Med	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (M August 26, 200	onth, Day, Year)
		,	L enn Street, Baltimore, MD 2120)1		
St Regist	ate trar	31. Date filed (Month, Day, Year) Registrar's Signature	arles			
DHMH 17 Rev 1/2	001	ORI	GINAL		OCME	

1 - State Registrar Certificate of Death	Dec No 0 0 0 0 0 0 0 71 0 0										
	Reg. No. 2009 271, 32										
1. Decedent's Name (First, Middle, Last) Physician MARY DiSTEFANO BASSO AUGUST	Day Year										
/iviedloal	C 23, 2009 6:30 P M										
FOREST HILL HEALTH & REHAB CENTER 4a. Facility Name (If not institution, give street and number) FOREST HILL HEALTH & REHAB CENTER FOREST HILL	HARFORD										
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of B	irth 9 Birthplace (State or Foreign										
Director 217-20-0259 15 M 221 83 Yrs. July 1	, 1926 Maryland										
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits										
Maryland Harford Forest Hill	1 ☐ Yes 2 X No										
10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?										
Maryland Harford Forest Hill 10e. Street and Number 109 Forest Valley Dr. 11. Marital Status 1 Never Married 2 Married	United States										
11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	o- 14. Race - American Indian, Black, White, etc.										
The part of the pa	Specify: white										
Specify:	16b. Kind of Business/Industry										
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle) 19. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 19. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) 19. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 10. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 11. Father's Name (First, Middle, Last)											
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The second state of the se											
Napoleon Disterano 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Num. 19b. Mailing Address (Street and Number or Rural Route Num. 19b. Mailing Address (Street and Number or Rural Route Num. 19c. Place of Disposition (Name of Date											
Frank Basso/son 911 Shephard Ct. Bel Air, 20a. Method of Disposition 20a. Method of Disposition 1 Revised 2 Competing 2 December, crematory or other place)	20c. Location - City or Town, State										
1X Burial 2	Garrison, Maryland										
21. Signature of Funeral Service Licensee 22. Name and Address of Fecility											
6500 York Rd. Baltimore	MD 21212										
shock, or heart failure. List only one cause on each line.	Oncot and Dooth										
Modical disease or condition resulting in death)	disease or condition resulting in death) a. Lewer Lew										
Due to (or es e consequence of): Examiner											
Sequentially list conditions, if any, leading to immediate Due to (or es a consequence of):											
Sequentially list of industry list of in											
Due to (or as a consequence of):											
cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):											
Y C S S S S S S S S S S S S S S S S S S	and Date of dally										
The standard of the standard o	23d. Date of delivery Month Day Year										
1 Yes 2 Mo 9 Unknown 9 Unknown 9 Unknown 23e. Did											
So by	tobacco use contribute to the cause of death?										
1 Detail of the control of the contr	Yes 2 No 3 Probably 4 Unknown										
24a. Was per such that the special such that	ppsy prior to completion of cause of										
25. Was case referred to medical examiner? Hospital: Hospital: 4 Description of Death (Check only of Death (Check											
Pospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Describe Pospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Describe Pospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Describe Pospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Describe Pospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Describe Pospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Describe Pospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Describe Pospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Describe Pospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Describe Pospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Describe Pospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Describe Pospital: 1 Inpatient 2 DOA Other: 4	how injury occurred										
27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Work? 1 Pending 2 Accident investigation											
27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 1 Homicide 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28b. Time of Injury 3 Suicide 4 Homicide 28c. Injury at Work? 1 Pending 2 No 1 Pending 28b. Time of Injury 4 North, Day, Year) 28b. Time of Injury 2 Suicide 4 Homicide 28c. Injury at Work? 1 Pending 2 North Advantage 2 No 28c. Injury at Work? 1 Pending 2 North Advantage 2 No 28c. Injury at Work? 28b. Place of Injury At home, farm, street, factory, office 28c. Location City or To	(Street and Number or Rural Route Number,										
in the second state of the	wn, State)										
The stand of the standard place and due to the standard place and due to the standard place and due to the standard place and place and place and due to the standard place and place and due to the standard place and place and due to the standard place and place and place and due to the standard place and place and place and due to the standard place and place and place and place and due to the standard place and	e cause(s) and manner as stated. e, date and place, and due to the cause(s)										
29a. Certifier 29b. Signature and title of certifier 29c. License number 29b. Signature and title of certifier 29c. License number 29b. Certifier 29c. License number 29b. Certifier 29c. License number 29b. Certifier 29c. License number 29d. Date signed (Month, Day, Year)											
- ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	angray 24 2005										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death **Physician** Month Day 904 HUSUS 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimal (niversita arvi . Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) TEB. 28, 19 Birthplace (State or Foreign Country) **Funeral** 1 🔀 M 2 🗆 F Months Days Min. Hours 219-96-7110 Director FEB. 41 1968 MD Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examination state notified at Director 1X Yes 2 No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 125 S. SCHROEDER ST. 21223 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 BLACK 1 ☐Yes 2 No ģ Yes. Give 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12TH TRUCK DRIVER TRUCKING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental 77 is marked c traumatic ever ဥ GENE CASTLE, SR. DORETTA CASTLE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a BARBARA CASTLE/WIFE : If item 27 or other t 125 S. SCHROEDER ST., BALTIMORE, MD 21223 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 5712 O DONNELL ST. 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) MT. CARMEL 08/28/2009 BALTIMORE, MD 21224 21. Signature of Euneral Service 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 2007-09 EASTERN AVE., BALTIMORE, MD 23a. Part 1. Enter the disease shock, or heart failure. d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician 10015 /Medical resulting in death) (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably ↓☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy 1 □ Yes 2 🔽 funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 | Yes 2 | 1√0 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐Yes 2 ☐No within 24 hours after death To the Funeral Director: in by the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined filled 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SI. BACTHORE, MD 2120 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician 9:00 AM Francisco Cantu 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Severna Park Anne Arundel 706 Wellerburn Ave. 8. Date of Birth (Month, Day, Year) 10-04-1912 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 □ F Months Hours Min. Director 96 451-14-6430 Texas Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits id other than "natural", or items 23a or 28a-f show event, the Modical Examinationst by notified at Director 1 ☐ Yes 2 No MD Severna Park Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 706 Wellerburn Ave. Funeral 21146 United States 12. Was Decedent Ever in U.S. Armed Forces? 11 Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1**Y** Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1X Yes 2 No Specify: 2 3 ₩ Widowed 4 □ Divorced Mexican White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If fem 27 is marked other than "any injury or other traumatic event, I're Magnes." United States Elementary/Secondary (0-12) College (1-4or 5+) 12 Sorter Postal Service 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Estanislao Cantu ပ Anita Castro 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Cantu / Son 3626 Peregrine Falcon Dr. Austin, TX 78746 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Sam Houston
National Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08-27-2009 San Antonio, Texas 21. Sign 1 - re of Funeral Service 1 ense Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CORONARY APTERY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has b 24a. Was an autopsy performed certificate 2 No 1 ☐ Yes 2 ☐ No 1 □Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After thi 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending hin 24 hours after death.

the Funeral Director: A
mpletely filled in by the fu investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D57531 41 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 May Sut 204, Millersville, NJ 2110 8601 Velerani mohitre 31. Date filed (Month, Day Year) AUG 2 7 2009 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\cap \cap \cap \) For State Registrer Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 24", 2009 **Physician** August 7:45 AM Charles N. Cope, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Baltimore COUNT OWSOR ourt Assisted Living Arden If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) DeC. 13, 1918 9. Birthplace (State or Foreign Country) Tennessee 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ☑ M 2 □ F Months Days Hours Dec. 90 219-07-8822 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or 28a-f show 1 Yes 2 No Directo MD Baltimore Towson 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21204 USA 8101 Bellona Avenue death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1□ Yes 2⊠ No Specify: Specify: Baltimore, Maryland 21215-003(white δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Attorney 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Is marked Ada M. Alder James O. Cope 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2: Department of Health ar Important: If item 27 Is 15425 SW 81st Avenue: Miami, FL 33157 Patrick S. Cope son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State • 4 ☐ Donation 5/ Other (Specify) Dulaney Valley Mem Gardens: 8/28/09 Timonium, MD 21. Signature of Funeral Service Licensee 1050 York Road Ruck Towson Funeral Home Inc. Towson, MD 21204 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one crude on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner eme Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 SOther (Specify) HSS & 2 1 ☐ Yes 2 No After this funeral of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification; 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To tha Hospital within 24 hours a To tha Funeral [12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MV au 32. Registrar's Signature 31. Date filed (Month, Day Year) State Registrar

acth

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Vear Month **Physician** 11:10% M Gylda Francine Clark July 20, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Cheverly Prince Georges Prince Georges Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days 1 ☐ M 2 🛛 F 577-74-0241 58 09/03/1950 Washington, DC Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1X Yes 2 No Director DC Washington, 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ŏ items 23a 4252 East Capital St, NE #102 20019 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23 any Injury or other traumatic event, the Medical Examirer must any Injury or other traumatic event, the Medical Examirer must ponce. Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 ☐ No Specify: Specify. 3 ☐ Widowed 4 🌠 Divorced Black Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Gov't 12 Investigator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Walter Smith Geneva Harris ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 707 Kaplan Court, Hyattsville, MD Alexis Duncan/Cousin 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory 8/21/09 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Austin Royster Funeral Home 21. Signature of Euperal Service Licensee M00996 3821 14th St., N.W., Washington, DC 20011 23a. Part I before the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm Mate Cause (Final Physician Fatal Cardiac Arrythmea dise se or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Metastatic Lung Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence or): Examine Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 ☐ Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 **X** No 1 □Yes 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760 P.O. Division of Vital Records, Hospital or Attending filled in by the f within 24 hours a

> State Registrar

DHMH 17 Rev 1/2001

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 💢 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Parvinder Khurana MD, 2150 Pennsylvania Ave., N.W., Washington, DC 20037

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D32132

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 21 2009 21:05 p.M Aug. Elesta L. Collins 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Harford <u>Upper Chesapeake Medical Center</u> Bel Air Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Days 1 ☐ M 2 🔀 F Pennsylvania 6, 1919 Jan. 214-07-5736 Usual Residence of Decedent 90 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2√∑ No Stone Mountain Georgia Deka1b 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 30087 2114 Minute Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2 DXNo Specify: Specify: White 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Factory Worker-Western Electric Manufacturing 11 vears 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frances Perdew Arnold Bennett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bel Air, Maryland 21014 (Daughter) 9 North Reed Street Carolyn Pecorino 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State 8/26/2009 Rossville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Gdns. of Faith Cem. 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Licen 7922 Wise Avenue Dundalk, Maryland 21222 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Facilitie to Thrive disease or condition resulting in death) Due to (or as a consequence of): Acute Kidney Facure on CKD

Physician /Medical Examiner physician and the burial-transit M 800514053 ital Records, P.O. Box 68760, use been signed by the should be detached funeral director, page 2

Physician

Examiner

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

If item 27 is marked other than "natural", or items 23a or 28a-f shor or other traumatic event, the Medical Expression is ust be nothed at

/Medical

Directo

by Funeral

Completed

Be

Examiner

Physician/Medical

Be Completed by

Certification: To

Medical

State Registrar

ary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Demention (Addition of the Communication of the	ranced)	ear elia	0687
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		pic pregnancy or (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions of	contributing to death but not resulting in the underly	ng cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?
			1 ☐ Yes	2 No 3 Probably 4 Unknown
			24a. Was an autopsy performe 1 ∐Yes 2 [ed? death?
25. Was case referred to medical examiner?		26. Place of Death	(Check only one)	
1 Yes 2 No	Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 [□ DOA Other: 4 □ Nursing Hom	ne 5 ☐ Residen	ce 6 Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) n		8d. Describe how	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		ctory, office 2	8f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)
	nysician: To the best of my knowledge, death occuminer: On the basis of examination and/or investig and manner stated.			
29b. Signature and title of certifier		29c. License number	290	d. Date signed (Month, Day, Year)

D0068014

1500 UPPER CHESBAPEAKE DR, Bel Air, MD-21014

DHMH 17 Rev 1/2001

HOSPITALIST

32. Registrar's Signature

30. Name and budress of person who completed cause of death (Item 23a) (Type, Print)

MASRINTHUE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav Year John Arrington Cooper 15P M August 24 2009 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Hospice
 If Under 1 Year
 If Under 24 Hrs.
 8. Date of Birth

 Months
 Days
 Hours
 Min.
 (Month, Day, Year)

 4 / 28 / 1 9 4 5
 5. Social Security Number 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) Funeral 043-34-0061 1 XM 2 | F 64 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21212 USA 5407 Purlington Way permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Psychologist Helathcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Jessica Beatrice Mitchell George King Cooper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5407 Purlington Way, Baltimore, MD 21212 Marilyn Short / Ex-wife Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State any injury or Ardent crematory 8/25/2009 Hanover, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Ucensee Dorota Marshall 22. Name and Address of Facility Maryland Cremation Services
Po Box 1413, Baltimore, MD Mauslea 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Physician iver canar disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate sician and burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical attending physic I for use as the b Cooper John IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Pregnant at time of death 1 Yes 2 No signed by the a 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ transplant Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😿 Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy death? 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: 24 hours after death.

Funeral Director: After this certificated filled in by the funeral director, I 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) らんしんかち 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completed fil Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nume Practioner To the best of my knowledge, death occurred at the time, date and place, and divert the causely) and numer as status. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R149194 Angust 24,2009

State Registrar

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8/24/19

N. Charles

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Towson

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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2009

Marion 31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 08/21/2009 Physician/ Shirley Gill Dunphy 3:10 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Towson GilchristHospice Care 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 □ M 2 👿 F Days Hours Min. 85 Yrs Director |216-16-6300 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits filed within 72 hours after death with the Maryland Director FLVenice Sarasota 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? by Funeral 468 Circlewood Dr. 34293 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 0. 1 ☐ Yes 2 🛣 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: white Completed 3 🕅 Widowed 4 🗆 Divorced Year or Dates the Medical 15, Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) own home r and Mental Hygien is marked other the Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bessie Howard Howard A. Gill permit. Page 1 and 2 should be Department of Health and Ment Important; If item 27 is marke any injury or other traumatic vonce. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra D. Grosh/Daughter 7810 Rockburn Dr., Ellicott City, MD 21043 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Atlantic Crematory 8/22/2009 Glen Burnie, MD 4 Donation 5 Other (Specify) 21. Signatu 22 Name and Address of Facility
Witzke Funeral Hones, Inc. of Funeral Service 5555 Twin Knolls Rd., Columbia, MD 21045 23a. P. rt 1. Enter the disc ase, or complications that caused stock, or heart ailure. List only one cause on each line ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Complications of disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) physician and the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 page 1 🗌 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: 1 🗌 Yes မ 4 Nursing Home 5 Residence 6 Other (Special Control of the Control 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1. Natural work? 1 ☐ Yes 2 ☐ No 5 Pending after death. Accident Investigation 3 Sulcide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined

Baltimore, Maryland 21215-0036 To the Hospital or Attending Physician; The law requires that the death certificate be executed Box 68760 Division of Vital Records, P.O. within 24 hours after de To the Funeral Directo completed filled in by th Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Secritifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified R149194 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 M. Charles 6701 G4 Towson. MD 21204 31. Date filed (Month, Day, Year) AUG 27 32 Registrar's Signature State Registrar DHMH 17 Rev 7/2009 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Frederick 1943 Doak 2009 August 24 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death University of Maryland Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 X M 2 □ F Months Days Hours Min. Oct 6, West Virginia 236-68-1806 1944 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 TXNo Directo Anne Arundel Maryland Crownsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1014 Omar Drive 21032 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No If Yes, Give Year or Dates: 1961–66 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Specify: White 1 ☐ Yes 2 X No Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Cherry Hill Elementary/Secondary (0-12) College (1-4or 5+) Construction Company 12 Diesel Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward မ Homer Doak Margaret McKinley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Crownsville, Maryland 21032 Simoine Mona Doak/wife 1014 Omar Drive 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🌠 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Ceme 8/31/2009 Crownsville, Maryland 21. Sign Jure of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 4 Romas Manita 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory distress disease or condition resulting in death) Due to (or as a consequence of): months Din small cell lung cancer Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Directo (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 10 1 ☐ Yes 1. ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation

Physician /Medical Examiner

Examiner

Funeral

Director

28a-f show

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23a

or items

"natural"

marked other than

alth and Mental Hv

. Pages 1 and 2 tment of Health a tant: If item 27 is

Department of Important: If it any injury or o

72 hours after death with

Baltimore, Maryland 21215-0036

Box 68760,

P.O. 1

Division of Vital Records,

other traumatic event, the Medical Examination nutitle notified at

Examiner Physician/Medical ₹ Completed Be

physician and s the burial-transit attending p for use as signed by the a been s has e 2 s page certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica this Certification: To After thi funeral neral Director: A Medical

Sourn Greane

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

7

and manner stated

H.D

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number 1992964977

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

24,2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 ☐ Could not be

determined

Sprect Baltimore, MD 21202 32. Registrare Signature

Jinny Ha, M.D.

August

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 200 <u>Anna Mary Decato</u> /Medical 4b. City, Town, or Location of Death ounty of Death 4a. Facility Name (If not institution, give street and number) Examiner 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) last birthday **Funeral** 1 □ M-2 🛛 F Director 94 12/20/1914 Maryland 054-10-9351 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ns 23a or 28a-f show must be notified at 1 ☐ Yes 2X No Director Harford MD Edgewood 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with U.S.A. 1222 Paul Martin Drive 21040 Funeral items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Examiner within 72 hours after 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2**X**) No Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2X No Completed by Specify: 3X Widowed 4 □ Divorced White "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Clothing Factory 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Tony Anapa Jennie Fuzzio 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health item 27 i Jennifer Lynn Watts (gr.daughter) 2775 Willoughby Beach Road - Edgewood, MD 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If ite any injury or ot once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem. 08/25/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of FacilityE. F. Lassahn Funeral Home, P.A. É 9 11750 Belair Road - Kingsville, Maryland Jass 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on vach line. Approximate Interval Between Onset and Death Immediate Cause (Final Limbra Physician O by mume disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner dichehrs VnHUHU Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine amenta The law requires that the death certificate be executed burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Proknown 1 Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Decato, Anna M. autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4☑ Nursing Home 5☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 TYes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8 m- D

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

AUG 2 7 2009

une

MO6

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ewis

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month AUGUST Day Year 4:45 P M 2 Physician/ 2009 MARY С. DUNI Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** BALTIMORE TOWSON GILCHRIST HOSPICE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** PENNSYLVANIA Months Days Hours Min. 206-16-1730 1 ☐ M 2 ☐XF 85 Yrs 1924 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f shov 10a, State the Maryland Director 1 X Yes 2 ☐ No BALTIMORE N/A MD. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a or Examiner must be Funeral UNITED STATES 7830 EASTDALE RD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo Black, White, etc þ 1 Never Married 2 Married 'natural", or WHITE Maryland 21215-0036 1 ☐ Yes 2 X No Specify: f Yes, Give Year or Dates 3 ₩ Widowed 4 □ Divorced Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygelen. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Eonce. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ JULIA SMITH JOHN McANDREW 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7830 EASTDALE RD., BALTIMORE, MARYLAND THOMAS DUNI/SON Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MARYLAND 8/29/2009 SACRED HEART OF JESUS 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 21. Signature of Funeral Service Lice 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between 23a. Part 1. Enter the disease of complications that caused shock, or heart failure list only one cause on each line Onset and Death Immediate Cause (Final disease or condition WELKS Complications Physician/ Lymphona Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Year in the past 12 months? Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 X No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Be Gilchrist Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death Certificate: iniury 1 X Natural 5 Pending 1 Yes Investigation 6 Could not be Accident within 24 hours after death

To the Funeral Director: A 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier R149194 August 24, 2009 RNP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) G701 N. Charles St MD 2 1200 Towson Marian Grant 31. Date filed (Month, Day, Year) AUG 2 7 32. Registrar's Signature State 2009 Eneral Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Marie C. Falkenhan August 23, 2009 4:40 A. /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3801 Roland Avenue Baltimore USA 8. Date of Birth Mar. 21, Year) 927 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2 🕅 Maryland Director 82 218-22-4004 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be nettined at 10d Inside City Limits Maryland N/A Baltimore Director XXYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3801 Roland Avenue 21211 USA filed within 72 hours after death v Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify White Specify: 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Federal Government Elementary/Secondary (0-12) College (1-4or 5+) Group Chief Audit Department 12 7 is marked other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be finent of Health and Mental Casper J. Falkenhan Katie May Davis ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra Deborah Falkenhan Niece 3742 Roland Avenue, Baltimore, Maryland 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Atlantic Crematory 8/26/2009 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OBSTRUCTIVE **Physician** Chronic pulmonar CLSEAST /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician: The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: use yes, outcome of pregnancy

☐ Live birth 2 ☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate performed 1 ☐ Yes 2 No 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 24 hours after death Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D35102 Omm() Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore maryland CHAVLES Street 5901 North DUN m.D. 31. Date filed (Month, Day, Year) AUG 27 32. Registrar's Signature State Registrar

09-06507 Donte Gunter

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 27444 1- For State Certificate of Death Reg. No Registrar 3. Time of Death 2. Date of Death Physician/ 1. Decedent's Name (First, Middle,Last) Month Day August 20, 2009 1724 hrs Medical Examiner DONTE DEMETISE GUNTHER 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore Johns Hopkins Bayview Medical Center If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 6. Sex 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** oreiar Min. Months Days Hours Country) MD Director 1X M 2 F 21 1983 216-06-9305 Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No s 23a or 28a-f shov e notified at once. BALTIMORE with the Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ā 125 S. HIGHLAND AVE 21224 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' death 1 X Never Married 2X No Yes Specify: BLACK Yes 2X No specify: be filed within 72 hours after Divorced If Yes, Give Year parment of Health and Menial Hygiene.

portant: If item 27 is marked other than "natural",

ury or other traumatic event, the Medical Examine. þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 CONSTRUCTION 12TH LABORER 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) CHERYL FLOYD WILLIAM GUNTHER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) HIGHLAND AVE., BALTIMORE, MD CHERYL FLOYD/MOTHER 125 S. 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 5500 O'DONNELL ST. Date 20a. Method of Disposition Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Pages 1 BALTIMORE, MD 21224 08/26/2009 Donation 5 Other Specify. TRINITY 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 21. Signature of Funeral Service/Licensee 2007-09 EASTERN AVE., BALTIMORE, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Multiple Gunshot Wounds Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner - Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical UNPENDED AMENDED attending physician or use as the burial -O. Box 68760 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy Month Day Year acco use contribute to the cause of death? þ No 3 Probably 4 V Unknown Records, P.

requires that the death certificate be executed Completed Division of Vital Be this Certification: To After

one)

Medical

past 12 months? 1 Yes 2 No 9 Unknown	Pregnant at time of death Unknown	5 Other (Specify)	2 Ectopic pregnancy	
art II. Other significant conditions	contributing to death but not result	ing in the underlying cau	se given in Part I.	23e. Did tob 1 Yes 24a. Was ar autops perform 1 Yes 2

								autopsy performed?	death?	etion of cause of
25	. Was case refer	red to medical	3			26.Plac	e of Death (Check	(only one)		
	examiner?	2 No	Hos	pital: 1	ER/Outpatient 3	DOA	Other: Nurs	ing Home 5 Residen	ce 6 Other:	
27 1 2	Manner of Deat Natural Accident	5 Pending		28a. Date of Injury (Month, Day Year) Aug 20, 2009	28b. Time of Injury 1635 hrs	1 1	ury at Work? Yes 2 ✔ No	28d. Describe how injur Subject shot	y occurred	
3		6 Could no determin	ot be	28e. Place of Injury - At h (Specify) Townhous	nome, farm, street, factorse / Rowhouse	ory, office	building, etc.	28f. Location (Street an or Town, State) 125 South Highland A		
	a. Certifier 1	Certifying Physi	ician:	To the best of my knowled	ige, death occurred at	the time, c	ate and place, ar	d due to the cause(s) and	manner as stated.	

2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated 29b. Signature and title of certifier 30. Name and address of person who completed cause

29d. Date signed (Month, Day, Year) 29c. License number August 21, 2009 O.C.M.E. OCME

111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Theodore M. King, Jr., MD.

31. Date filed (Month, Day, Year) State Registra

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

cott Michael Gre	1-	For State Ce	ertificate of Death	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Reg. No.	2.0	00 071
Physicia		edistrar . Decedent's Name (First, Middle,Last)	OPERADEDO		te of Death onth Day gust 22, 200	Year	3. Time of Death /
ledical Examir	ner	SCOTT MICHAEL	GREENBERG 14b. City, Town, or L			c. County of Death	
	4	a. Facility Name (if not institution, give street and number) 2307 Velvet Valley Way	Owings Mills	3	1	Baltimore Cou	
Funeral Director		• • •	last birthday) If Under 1 Year Months Days	1	ate of Birth (MM 3/01/19	1/DD/YYYY) 9. Birt Foreig Cor	hplace (State or n untry) MD
		Jsual Residence of Decedent	ty, Town or Location				10d. Inside City Limits
w any		MD BALTIMORE	OWINGS MIL	1.5			1 Yes 2 No
Maryland 28a-f show d at once.	황	10e. Street and Number	10f. Zip Code		10g. Ci	tizen of What Cour	ntry?
the Ma a or 28	Director	2307 A SHADY BROOK DRIVE	2111			USA	
72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho al Examiner must be notified at once.		11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No	If Yes, specify Cuban	panic Origin? (Specify , Mexican, Puerto Ricar	Yes or No- n, etc.)	White, etc.	can Indian, Black,
	J. F.	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X No		long 116h	Specify: WHI	
hours naturi Exami		15. Decedent's Education (Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occupat during most of working life	. DO NOT use retired)	ione Tob	Nilla of Basinessi	
5-0036 led within 72 hours after Bygiene. other than "natural", the Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	OWNER			FOOD SER	RVICE
e, MD 21215-0036 I and 2 should be filed within 7 Health and Mental Hygiene, riten 27 is marked other than r traumatic event, the Medica		17. Father's Name (First, Middle, Last)		18.Mother's Name (Firs	t, Middle, Maide	en Surname) KESSI	ED
10re, MD 21218 ages I and 2 should be file nt of Heath and Mental H tt: If item 27 is marked other traumatic event, t	Be	FRED GREENB 19a, Informant's Name/Relationship (Type, Print)	L KU 19b. Mailing Address (Stree		Route Number,		
MD 2 d 2 shoul lith and M n 27 is m	٩	FRED GREENBERG / FATHER	2307 VELVET	VALLEY WAY	, OWING	S MILLS,	MD 21117
ore, Mes I and 2 of Health If item 2	- 1	20a, Method of Disposition 1 X Burial 2 Cremation 3 Removal from State	 b. Place of Disposition (Name of ce crematory or other place) 	metery, Da	te 20	c. Location - City o	r Town, State
- s 4 = 91		4 Donation 5 Other Specify:	ETH EL MEMORIAL	PARK 08/24	/2009	RANDALLS'	TOWN, MD
Baltimore, permit. Pages I an Department of Hea Important: If iten injury or other tra	1	21. Signature of Funeral Service Aconsee	22. Name and Addres	s of Facility SOL STERSTOWN R	LEVINSO	N & BROS	., INC. MD 21208
Physician		23a. Part I. Enter the disease, or complications that caused the de	ath. Do not enter the mode of dying	, such as cardiac or res	piratory arrest,	shock, or heart	Approximate Interval Between Onset and
Medical (aminer	1	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Gunshot Wo	ounds				Death
	L	Sequentially list conditions, if any leading to immediate Due to (or as a consequence	on of):				
	nine	cause Enter Underlying Couse					10
nd cuted	Medical Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence d. d.	/e of):				
be execution a nitial -	dica	UNPENDED AMENDED				23d Date of dolly	200
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transi	/Me	IF FEMALE: 23c. If yes, outcome of p 23b. Was decedent pregnant in the 1 Live birth		Ectopic pregnancy	- 1	23d. Date of delive Month	Day Year
Division of Vital Records, P.O. Box 687 ta or Attending Physician: The law requires that the death certificar an Director: Affect this certificate has been signed by the attending pled in by the funeral director, page 2 should be detached for use as the	Physician/	past 12 months?					
Bo he deal	hys	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but n	not resulting in the underlying cause	given in Part I.	23e. Did tobac	cco use contribute	to the cause of death?
P.O s that t gned by	by	Fait II. Other significant containers Communing to death Davis	, ,		1 Yes	2 No 3 P	robably 4 Unknown
ds, equire een sig	Completed				24a. Was an autopsy		autopsy findings available completion of cause of
e law re law be law law be law	햩				performe 1 ✓ Yes 2		
I Re II: The rtificat or, pag	ပ္ပို	25. Was case referred to medical	26.Pla	ce of Death (Check onl			
Vita hysicia this ce	B B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2		Other Nursing H		sidence 6 Ot v injury occurred	ner: Scene
Ing P	I :	27. Manner of Death 1 Natural 5 Pending Pending	1	ijury at Work? 28 Yes 2 ✓ No	ibject was s	hot	
ivisior or Attend after death Director: d in by the	cati	2 Accident Investigation Aug 22, 2009 28e. Place of Injury	2127 hrs At home, farm, street, factory, office	e building, etc. 28	f, Location (Stre	eet and Number or	Rural Route Number, City
Divi	Certification:	3 Suicide 6 Could not be determined (Specify) Single		23	or Town, Stat 07 Velvet Vall	e) ley Way, Owings	Mills, MD
Hospi 24 hou Funer tely fil	Medical Co	29a. Certifier 1 Certifying Physician: To the best of my knowne) 2 ✓ Medical Examiner: On the basis of examination	wledge, death occurred at the time, ion and/or investigation, in my opini	date and place, and du on, death occurred at the	ne to the cause(s ne time, date an	s) and manner as s d place, and due to	tated. the cause(s)
To the within To the comple	Med	29b. Signature and title of certifier		nse number	2	29d. Date signed (Month, Day, Year)
		Carl H	0.0	C.M.E.		August 23, 20	09
O_I		30. Name and address of person who completed cause of death		altimore MD 212	01		
\		Jack Titus MD. Deputy Chief Medical Exam		alumore, MD 212			
Regi	State	ALIC OF COOC	barlo				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19b Per FH G894 8/31/09 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Joseph Bernard Holzinger August 2009 4:10 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Northwest Hospital Randallstown Baltimore If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number Sex 1XXM 2□ F 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) **Funeral** Days Switzerland Director 217-26-2575 96 Apr 19.1913 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the "ho, it all Examiner must be notified at MD Howard Elkridge 1 Tyes 2 No Director filed within 72 hours after death with the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6362 Forest Avenue 21075 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White ģ '42-'45 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Man Elementary/Secondary (0-12) College (154or 5+) Pumper Chemical Plant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Holzinger Anna Urnaver ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7337 Algonne Drive Patricia Hasenei (Daughter) Marriottsville, MD 21104 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial Park 8/26/09 Elkridge, MD ^{22.} Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, 7250 Washington Blvd. Elkridge, MD 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that dayed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enail Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) signed by the a P.O. I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by autopsy certificate ! 1 □ Yes 2 1 ☐ Yes 2 □ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Sother (Specify) Lpah (1) Medical Certification: To this 28a. Date of Injury (Month, Day, Year) After th funeral Manner of Death While 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural
2 Accident Injun within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MI 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21136 Main 200 Reisestown

DHMH 17 Rev 1/2001

State Registrar 31. Date fifed (Month, Day, Year)

32. Pegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar		() () () () () () () () () ()	Certifica	ate of l	Death	н	eg. No	09	274	14/
	Discolati		1. Decedent's Name (First, Middle, La.	st)					2. Date of Dea Month	th Day	Year	3. Time of	Death
	Physici /Medio		Delmar Reese	Horner					August	25	2009	6:45	P M
	Examir		4a. Facility Name (If not institution, giv			4b. Cit	ty, Town, or	r Location of Death	1		nty of Death		
nga?			11809 Legore Bri			1611-		Keymar			rederi		
	Funeral Director		5. Social Security Number 220–28–8514 Usual Residence of Decedent	Sex 7.Ag	e (In yrs. last birth	month rs.	der 1 Year Is Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day July 16	(Year)	Coun	place (State of htry) yland	r Foreign
	land ow		10a. State 10b. County		10c. City, Town	or Location					11	0d. Inside Cit	y Limits
	Mary F sh	ţ	Maryland Fre	derick			ĸ	Kevmar				1 ☐ Yes	2 🔀 No
	r 282	Director	10e. Street and Number	acrick		10f. 2	Zip Code	ic y ii az	1	0g. Citizen o	of What Coun	try?	
	h witl	a D	11809 Legore B	ridge Rd.			21	757			U.S.	.A.	
	ems	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S.	13. Was Dec	cedent of H	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. R	tace - Americ		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, it of Safet Examination that I will a some.	by	1 ☐ Never Married 2 【X Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ N If Yes, Give Year or Dates:			2 ⊠ №	Specify:	o / Houri, otoly	Spec	oifu -	ite	
2-(72 h	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	î (Decedent's Us Give kind of t	vork done d	during most of wor	king	16b. Kind of	Business/Inc	lustry	
121	within iene. than "	귵	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. DO NOT			ı		aa fox	m mein	tina
9	illed v Hygić ther i		17. Father's Name (First, Middle, Last))		5	uperv		ne (First, Middle, i			m prin	.cmg_
an	should be f and Mental s marked o iumatic eve	To Be	Clyde Reese						lian Ire		,		
Σ	2 shoul and Mi Is marl aumati	۲	19a. Informant's Name/Relationship (19b.	Mailing Addre	ess (Street	and Number or Ru				Code)	
	nd 2 (all the all the		Margaret Horner/	wi fe	11	809 Te	gore	Bridge R	d. Kev	mar, M	1D 2175	57	
re,	s 1 and 2. of Health a ltem 27 is		20a. Method of Disposition		20b. Place of I				Date	20c. Location			
E	Pages nent of ant: If Its Iry or o		1 ☐ Burial 2 【X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif					ion 8/29	9/2009	Svkes	ville.	MD	
Baltimore,	permit. F Departm Importar any Injur		21. Signature of Funeral Service Licer	O. Lant	Her	22. Name	and Addres	ss of Facility Ha	rtzler F Woodsbor	uneral	L Home		
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. Do no							Approximate	9
	Physician	0	Immediate Cause (Final	one cause on each lir	ie. Caci	arc	pae	mona	y are	とのし	2.	Onset and D	eath
	/Medical		disease or condition resulting in death)	a. Due to (or as	a consequence of	carc	RIOL	myga	ry t	F34	0	5 /2	410
and a	Examiner			Ast	VD- A	Thes	aSic	lecas	٠ ا		1	072	8
3	P +	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):							
	ecute ind transi	Examiner	that initiated events	o. Hyp.	esteu	210	in				2	20)	cks.
90,	be excisin a	ũ	resulting in death) Last	The to fores	a con * quence of): A			211 - 22-2				,
68760,	rtificate be executed ng physician and sas the burial-transit	Medical		_d	alles	1	olu	etous	et		1	5 7	N.
Вох	leath certific attending p for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal death	3 Ectopic		у		1	Date of delive		/ear
Ö.	t the c by the achec	hysi	1 □Yes 2 □No 9 □ Unknown	9 Unknown									
rds, P.	The law requires that the death ce atendiate has been signed by the attendionage 2 should be detached for use	þ	Part II. Other significant conditions of	ontributing to death b	ut not resulting in t	the underlying	g cause give	en in Part I.	23e. Did to	20		necause of do oably 4 □ U	
ပ္ပ	s bee	lete	On as much	1 000	en de	u To		0 700	24a. Was a	in 241	b. Were auto	psy findings a	available
Division of Vital Records,	ician: The lav certificate has ector, page 2 t	Completed	25. Was case referred to medical				inc			med2 2000	death?	mpletion of ca 2 □ No	ause of
5	/sicia s cert directe	o Be	examiner?	Hospital:	ent 2 🗍 ER/Out	nationt 3 🗆	DOA Othe		th (Check only or	<i>ne)</i> ence 6 □C	Other (Specif	54)	
O	ing Phys n. After this funeral di	n: To	27. Manner of Death	28a. Date of Inju (Month, Da	ry 28b. Ti	me of	28c. Injur		28d. Describe h			<u>y)</u>	
ō	ath. r: Aft	aţe	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		y, rear) III	ury M		Yes 2□No					
Divis	Hospital or Attende to the saft of the saf	ertification:	3 Suicide 6 Could not be determined		iry - At home, farn c. (Specify)	n, street, facto	ory, office		28f. Location (S City or Tow	treet and Nur n, State)	mber or Rura	ıl Route Num	ber,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical C		nysician: To the best on the basis of and manner sta	f examination and)
0	To th withii To th	Ž	29b. Signature and title of certifier	_		2	29c. License	e number	2	29d. Date sign	ned (Month,	Day, Year)	
			Bouta Tese	2100 l-S	Meri	001	Hoos	44057	C	38-2	6-2	009	
			30. Name and address of person who	completed cause of d	eath (Item 23a) (T	ype, Print)	Y	121	-123,0	U287-6	Maria	87-1R	real.
			Banta J. Kl) ginftl	- far	FIER	DO	Em	in TSlo	uf,	MP	-212	27
	Sta Registr		AUG 27 2009	Jeneva 32. Registra	s Signature				·				,

Physician
/Medical
Examiner

Fune Direc

Baltimore, Maryland 21215-0036

Physici /Medic Examin

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely tilled in by the tuneral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	•	for State Registrar	Otate of Ma	-	ertificate of			leg. No.2	09	27448		
icia	n	1. Decedent's Name (First, Middle,					2. Date of Dea Month	Day	Year	3. Time of Death		
dica	al	DIONISIOS K. HA			4h City Town o	r Location of Death	AUGUST		009 ty of Death	7:45 A"		
nine	er	411 S. MACON ST			BALTI				N/A			
ral		1	1 D M 2 D F	(In yrs. last birthda	Months Days	If Under 24 Hrs. Hours Min.	(Month, Day	(, Year)	Cour			
or		Usual Residence of Decedent	7	7 Yrs.			OCT. 28	, 1931	CHIOS	GREECE		
OF .		10a. State 10b. County		10c. City, Town or	Location				1	0d. Inside City Limits		
	ctor	MD. N/A	<u> </u>	BALT	TIMORE					1X∑Yes 2 No		
	Dire	10e. Street and Number			10f. Zip Code	0100/		10g. Citizen of				
	by Funeral Director	411 S. MACON ST	12. Was Decedent E	ver in U.S. 1:		21224 dispanic Origin? (Sp		JNITED 14. Ba	STATE ace - Americ			
	Fun	11. Marital Status 1 ☐ Never Married 2 Married	Armed Forces?	0	Was Decedent of If Yes, specify Cub		Rican, etc.)		ack, White,			
		3 Widowed 4 Divorced	If Yes, Give 24 Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Spec	ify: WHI	TE		
	ete	15. Decedent's (Specify only highest	Education grade completed)	I (Gi	cedent's Usual Occup ive kind of work done e. DO NOT use retire	during most of work	ing	16b. Kind of	Business/Ind	dustry		
	Completed	Elementary/Secondary (0-12) 5TH	College (1-4or 5-	-)	PAINTER			COI	NSTRUC	CTION		
	17. Father's Name (First, Middle, Last) KONSTANTINOS HATZIDAKIS THEODORA											
		19a. Informant's Name/Relationship THEODORA WHITE			ailing Address <i>(Street</i> 3 S. MACON		ral Route Numbe LTIMORE	-		21224		
	- 1	20a. Method of Disposition		20b. Place of Dis	sposition (Name of	1	Date	20c. Location		own, State		
,	1 Notice Surial 2 Cremation 3 Removal from State Cemetery, crematory or other place) State Sta											
once.												
ā		John C	Uto						CYLAND			
		23a art 1. Enter the disease, or co shock, or heart filure. List or mmediate Cause Final	omplications that caused only one cause on each lin	e.	enter the mode of dyr	ng, such as cardiac	or respiratory ar	iest,		Approximate Interval Between Onset and Death		
an al		disease or condition resulting in death)	a. Due to (or as a	consequence of):	D .		1	1				
er		Sequentially list conditions,	b	eriphe	erel	Vaseu	dar e	11000	he			
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Due to or as a	consequence of :								
	xan	that initiated events resulting in death) Last	cDue to (or as a	consequence of):								
	cal		d									
	Completed by Physician/Medical	IF FEMALE:						1	10.00			
	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	2 Fetal death	3 Ectopic pregnanc	су			ate of delivitionth	ery Day Year		
	iysic	1 □Yes 2 □No 9 □ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of death	5 Other (specify) _							
	y P	Part II. Other significant condition	s contributing to death bu	t not resulting in the	e underlying cause giv	ven in Part I.	23e. Did to	bacco use co	ntribute to t	he cause of death?		
	ed b						1)X(1	es 2□No	3 ☐ Prol	bably 4 🗆 Unknown		
	plei						24a. Was a	sy	prior to co	opsy findings available ompletion of cause of		
	Sol							2 DXNo	death? 1 ☐ Yes	2 🗆 No		
	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatie	at 2 DEB/Outro	tient 3 DOA Oth	26. Place of Deat			Whor (O			
	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred											
	atio	1 Natural 5 Pending 2 Accident investiga	tion	, rear) Injur		Yes 2 No						
		3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ry - At home, farm, . (Specify)	street, factory, office		28f. Location (5 City or Tow	Street and Nur n, State)	nber or Run	al Route Number,		
	င္ဗ	29a. Certifier 1 Certifying	Physician: To the best of	of my knowledge, de	eath occurred at the t	ime, date and place	, and due to the	cause(s) and	manner as:	stated.		
	edic		kaminer: On the basis of end manner sta	examination and/o								
	Σ	29b. Signature and title of certifier	1 1		29c. Licens	se number	03	29d. Date sign	ned (Month	Day, Year) 2009		
		P - 305_()	المداء و		3		~		′1			
		30. Name and address of person w	ho completed cause of de	eath (Item 23a) (Typ	pe, Print)	- B-	HC.	MD	21	524		

State

Registrar

31. Date filed (Month, Day, Year)

AUG 27 2009

32. Registrar's Signature

			For State Registrar	State	of Marylar	•	artment of H rtificate of		d Mer		giene leg. No.	009	27449
			1. Decedent's Name (First, Middle, La	ist)					2.	Date of Dea Month	th Day	Year	3. Time of Death
	Physici /Medic		Shirley A. Hall						A	lug.	24	2009	2:00 a. M
	Examir	ner	4a. Facility Name (If not institution, gi	ve street and nu	ımber)		4b. City, Town, o		eath			ounty of Death	
ř			7210 Gunpowder 5. Social Security Number 6.				Middle If Under 1 Year		re la	Date of Birth		altimor	e place (State or Foreign
	Funeral Director			sex i□ M 2 X □ F	7. Age (In yrs.	. <i>iast birthday)</i> Yrs.	Months Days		lin.	(Month, Day	, Year)	Cou	intry)
	and the same of		Usual Residence of Decedent		74				l Iv	larch	Z, 19.	33 Mar	yland
	yland		10a. State 10b. County		10c. Ci	ity, Town or Lo	ocation						10d. Inside City Limits
	e Mai	çç	Maryland Baltim	ore	M	iddle H	River						1 □ Yes XXNo
	if th	Director	10e. Street and Number				10f. Zip Code				10g. Citiz	en of What Cou	ntry?
	ath w		7210 Gunpowder Ro				2122					ited St	
	er de items	Funeral	11. Marital Status	Armed Fo		J.S. 13. \	Was Decedent of H If Yes, specify Cub	lispanic Origin? an, Mexican, Pu	(Specify Jerto Rica	Yes or No- an, etc.)	1.	 Race - Amer Black, White, 	
36	rs aft	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes If Yes, G Year or D	ve		1 □Yes 2 🔼 No	Specify:			5	Specify: W	hite
21215-0036	2 hou	ted	15. Decedent's E	ducation			dent's Usual Occup			I	16b. Kin	d of Business/Ir	434
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pu	be fill tal H id oth	Be	17. Father's Name (First, Middle, Last					18. Mother's N	,				
<u>Ş</u>	ould Mer narke	ြင	Russell Clift		111	T		L		rie Pi			
Maryland	d2sh than 7 Isn traun		19a. Informant's Name/Relationship		ow)		ng Address (Street						
e,	1 and Heal em 2		Shirley Hall 20a. Method of Disposition	(Daught			O Gunpowo esition (Name of matory or other place		Date			ation - City or T	21220 own, State
JO L	ages ent of it: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		State		natory or other place. Cemetery		31/2	2009	Do.	ltimoro	, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the "Modral Eratic in a functional by notified at once.		21. Signature of Funeral Service Lice	1	Joan	22	Name and Addre	ess of Facility					
ä	permi Depar Impo any Ir		1 Willal	$\angle //$	سيدو	1	Ouda-Ruck 7922 Wis						nc. 1222
	Dharinin		23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	one cause on e	caused the dear	th. Do not ent						ní Is	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	_ a	(or as a consec	quence of):		A -	-)-	-0	V ·		(-1100)
	Examiner			_ (Lora	nan	2 An	ery	1	boes	22	_	cen- Kiron
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8760,	cate be ex ohysician the burial.		resulting in death) Last	Due to	(or as a consec	quence ot):							
187		dical		d									
9 x	eath certific attending p for use as t	Physician/Me	IF FEMALE:	23c. If yes, ou	tcome of pregn	ancy					25	3d. Date of deli	verv
Box	death atter	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No		birth 2 Feta		Ectopic pregnand Other (specify)	У				Month	Day Year
P.O.	that the de	hysi	9 Unknown	9 🔲 Unkr	nown		1, 7,						
	ires tha signed I be det		Part II. Other significant conditions	contributing to d	leath but not res	sulting in the ur	nderlying cause giv	en in Part I.		23e. Did to	bacco us	e contribute to	the cause of death?
ord	The law requires ate has been sign page 2 should be	Completed by	Lung Can	we g	· CH	f-,	(0 81	<i>)</i> ,	- !	1 🗗 Ý	es 2□]No 3☐ Pro	bably 4 Unknown
ပို	law ra as be 2 sh	plet								24a. Was a	an sv	24b. Were aut	opsy findings available ompletion of cause of
E	The ate h	ĕ								autop perfor 1 ☐ Yes	med? 2 No	death? 1 ☐ Yes	
/ita	iclan: The certificate ector, pag	Be (25. Was case referred to medical examiner?					26. Place of I	Death (C	heck only or	ne)		
<u>}</u>	Physic this c		1 Yes 2 No			ER/Outpatier		4 LI NUISIII				☐Other (Spec	rify)
n C	or Attending Physician: The law requires that the death certificate death. Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use as	<u>io</u>	27. Manner of Death 1 ☑ Natural 5 ☐ Pending		of Injury oth, Day, Year)	28b. Time of Injury	Wor		28d	. Describe h	ow injury	occurred	
isi	death death stor: / the 1	icat	2 Accident investigation 3 Suicide 6 Could not be	0	of Injury - Ath	nome farm str		lYes 2 □ No	28f	Location (S	treet and	Mumber or Pu	ral Route Number,
Division of Vital Records,	tal or A rs after al Directed in by	Certification: To	4 ☐ Homicide determined				eet, factory, office			City or Tow	n, State)		
A	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier (Check only one)	miner: On the t	e best of my kno pasis of examina nner stated.	owledge, deatl ation and/or in	h occurred at the ti vestigation, in my	me, date and popinion, death o	lace, and	due to the at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
9	To th within To th comp	Me	29b. Signature and title of certifier	4.0			29c. Licens	se number	· / ·		29d. Date	signed (Month	, Day, Year)
			100	ベン ^ト			V-	307	>4	1	00	7-25-	-2009
			30. Name and address of person who	completed cau	se of death (Ite	m 23a) (Type,	Print) ASTBA	en D	LVÍ) ,	M	0-2	1221.
	Sta	ite	31. Date filed (Month, Day, Year)	000 32.	egistrar's Signa	ature	arke						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** 1:15 1 M Kobe - + 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Beltino Bellimore Hospital If Under 1 Year | If Under 24 Hrs. 6. Sex 1X M 2 ☐ F 8. Date of Birth (Month, Day, May 25, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Yrs. 1939 Pennsylvania Director 212-36-4026 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f sho the Medical Exprainer is ust be notified at 1 ☐ Yes 2 X No Director Rosedale Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with Funeral Unit 104 21237 United States 6708 Ridge Road 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify. þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' ury or other traumatic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver/Teamsters Transportation 11 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thelma Mae Bloom Albert Kenneth Heffler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6708 Ridge Road, Unit 104 Rosedale, Md. 21237 Mrs. Dorothy Heffler (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page Department o Important: If any injury or once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Serv. Corp. 8/26/2009 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 23a, Part 1. Enter the disease, shock, or heart failure. List immediate Cause (Fir disease or condition resulting in death) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death List only one cause on each line **Physician** Ischemic stroke 2 244> /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760 Physician/Medical been signed by the attending p should be detached for use as IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by abrillation 3 Probably Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? cerebellar 24a. Was an certificate has birector, page 2 s Miston etrok & autopsy Hickory 2□No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case refer d to medical examiner? funeral director 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2∏No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Natural 5 Pending ours after death.

leral Director: A
filled in by the fu investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 hou

To the Fune

completely fi Medical and manner stated

State

DHMH 17 Rev 1/2001

Registrar

29b. Signature and title of certifie

Franklin

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

Hospita)

32. Registrar's Signature

29c. License number

D0053694

29d. Date signed (Month, Day, Year)

9000 Franklin Square Huspital Drive, Baltimore, MD, 2123)

			State of Maryla 1- State Amend Items 23e,24a,2	nd Depa 5,27,28 <i>Cer</i>	rtment of H i per dr. tificate of l	Death			2745
1	Physici	an	1. Decedent's Name (First, Middle, Last) Robert Holmes				2. Date of Dea Month	Day Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution, give street and number)		4b. City. Town, or	Location of Death	Augus	4c. County of Dea	
Y	Examin	ier	Genesis Randallstown		Randall	stown		Baltimor	e
	Funeral			rs. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	y, Year) 9. Bi	rthplace (State or Foreign ountry)
н	Director		219-26-9419 69 Usual Residence of Decedent	9 Yrs.			Oct 11,	1939 Mar	yland
	land ow			City, Town or Lo	cation				10d. Inside City Limits
	Mary a-f sh ffied a	tor	MD Baltimore Ra	ındal1st	own				1 □ Yes 2½ No
	or 28% e not	Oirec	10e. Street and Number		10f. Zip Code			10g. Citizen of What C	ountry?
	ath wi	ral	9109 Liberty Road		21133			USA	aviaca Indiaa
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☐ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 □ No If Yes, Give Year or Dates: unk		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2☑ No	ispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Am Black, Wh Specify: W	ite, etc.
20	72 ho natur ilcal	eted	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup	during most of wor	king	16b. Kind of Business	s/Industry
12	vithin ne. han "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		DO NOT use retired sabled	d) -		none	ale
	filed v Hygie ther i	ပ္ပို	17. Father's Name (First, Middle, Last) unk	u.r.	Jabrea	18. Mother's Nam	ne (First, Middle,	Maiden Surname)	
an	should be f and Mental I s marked of umatic eve	To Be				Martha	Bacon		
Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Me	-	19a. Informant's Name/Relationship (Type. Print)	l l	•			er, City or Town, State,	
	1 and 2 Health a em 27 is		Jean Holmes/former wife			treet; Fr		North Caro	
Baltimore,	permit. Pages 1 an Department of Heal Important: if item 2 any injury or other once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 3 ☐ Other (Specify) In State		matory or other plac		Date	20c. Location - City o	
Balt	permit. Depart Import any in		21. Signature of Funeral Solvice Licensee Ronal d S. Wade, Director		Name and Addre State Ana Baltimore			. Baltimore	e Street
	Physician /Medical Examiner		23a. Pall 1. Enter the dis ase, or complications of at caused the deshibit, or heart failure. List only one cause on each line. Immedial Cause (Final disease or condition resulting in leath) a. Due to (or as a constitution of the condition of	Throm					Approximate Interval Between Onset and Death
68760,	icate be executed physician and s the burial-transit	edical Examiner	Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a constitution of the constitution	sequence of).					
.O. Box	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome pf pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of	etal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of d Month	elivery Day Year
rds, P.	quires tha in signed I uld be det	by	Part ii. Other significant conditions contributing to death but not	resulting in the u	nderlying cause giv	ven in Part I.		obacco use contribute Yes 2□No 3□	to the cause of death? Probably 4xIUnknown
I Records,	The ate ha	Completed				<u> </u>	24a. Was autop perfo 1∐ Yes	an 24b. Were prior to death?	
or Vital	Physician; this certificanal director,	Be	25. Was case referred to medical examiner?		12::		ath (Check only o	one)	
<u>or</u>	Physic this c al dire	မ	1 Yes 2 No Hospital: 1 Inpatient 2 27. Manner of Death 28a. Date of Injury	2 ER/Outpatier 28b. Time o		4 Nursing F	T	dence 6 Dother (S _i	pecify)
Division	To the Hospital or Attending I within 24 hours after death. To the Funeral Director; After completely filled in by the funer	Certification:	1 X Natural 5 ☐ Pending investigation 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - A building, etc. (Special County)	r) Injury	M 1	lyes 2∐No		Street and Number or	Rural Route Number,
	e Hospita 124 hours e Funeral letely filled	Medical Co	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my 2 Medical Examiner: On the basis of exam and manner stated.						
	To the vithin To the Complex c	Me	29b. Signature and title of certifier		29c. Licens	se number		29d. Date signed (Mo	nth, Day, Year)
			Last crop		R144	1682		August 1	3,2009
			30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	100	2/12/		
	Str	ate	31. Date filed (Month, Day, Year) 32. Registrar's Si	ignature ,	estown,	, 1110 9	1106		
	Regist		35 Main Street Ste 200 31. Date filed (Month, Day, Year) AUG 27 2009 AUG 27 2009	A. pa	Kal				

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				1 - For State Registrar	Otato of Mic	ar yraria / L	-	icate of			Reg. No.	2019	27452
				Decedent's Name (First, Middle, I	ast)					2. Date of Dea	-	gs band but med	3. Time of Death
		Physici /Medi		Lula	Howe	21/				Aug	23	2009	7:14 AM
	The same	Examir		4a. Facility Name (If not institution, g	give street and number)		4	c. City, Town, o	r Location of Death			County of Death	
	1			21nai HOSPI	Sex 17. Age	Cutting e (In yrs. last bir	DR Thomas	Under 1 Year	If Under 24 Hrs.	8 Date of Birth	N/F	9 Birth	inlace (State or Foreign
		Funeral Director		5. Social Security Number 216-62-697 Usual Residence of Decedent	1 M 2 F	-		onths Days	Hours Min.	8. Date of Birth (Month, Day	1955	mary	place (State or Foreigr Intry) (2)C
		ow ow		10a. State 10b. County		10c. City, Town	n or Locat	on					10d. Inside City Limits
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3		or 28%)ire	10e. Street and Number	10.4. 0			10f. Zip Code	_			en of What Cou	intry?
P		23a c	Funeral Director	2525 W. Belv	edere Av	e.		21215			USA		
1		er dez	nue	11. Marital Status	12. Was Decedent E Armed Forces?	_	13. Was	Decedent of H s, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- Rican, etc.)	. 1	 Race - Amer Black, White 	
	36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes 2 ☑ If Yes, Give Year or Dates:	40	1 🗆	Yes 2 No	Specify:		;	Specify: 6/	ack
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5	yla	should b ind Ment marked umatic e	2	Irvin Carter					Daisy	Mice	Cra	_	
a	, Maryland	1 and 2 sh Health and tem 27 is m		19a. Informant's Name/Relationship	(Type. Print)	36	o. Mailing <i>I</i> 635	Pulasi	and Number or Ru Ki HWY	Baltima			a 24
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Z	Bal	permit. Departr Importa any Inji	e li	21. Signature of Funeral Service Lic	Gragon	/	27	o Fred	4 of Escility Prays	ass Ba		nore m	D 21229
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	O. Bo	0 00 0	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No		2 Fetal death		ctopic pregnand ther (specify) _	су			Month	Day Year
1	σ,	hat the de od by the letached	Phy	9 ☐ Unknown Part II. Other significant conditions	e contributing to death h	ut not resulting i	n the unde	rlving cause di	ven in Part I	23e. Did to	obacco u	se contribute to	the cause of death?
8	rds,	quires that in signed I uld be det	d by		Ilítus i	Hypo	mbon		chesity	1 🗆 🗅	Yes 2]No 3□Pr	obably 4 Unknown
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	a	sician: The la certificate ha rector, page a									rmed? 2X No		2 □No
	Ζit	Physician: this certifica al director, p	Be C	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ent 2 ER/O	utnationt	3 DOA Oth	26. Place of Dea	th (Check only come 5 Residence		Other /s=-	oifu)
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	ion	Attending F death. ctor: After y the funera	atio	1 Natural 5 Pending 2 Accident investigat		y, rear)	Injury		rk?]Yes 2□No				
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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 8-24-2009 D30494 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) maiden choice DETHI MO 716 31. Date filed (Month, Day, Year) 32. Redstrar's Signature

State Registrar

Medical

29a. Certifier

AUG 27

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 09 Wones Huna /Medical 4a. Facility Name (If not institution, give street and number 4h City Town or Location of Death 4c. County of Death Examiner stei Birthplace (State or Foreign Country) Date of Birth (Month, Day, Yea /18/1928 7. Age (In yrs. last birthdav) 5. Social Security Number **Funeral** Months Days Hours Min 1 □ M 212 F 213-22-5234 Yrs Director 81 Maryland Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County 28a-f show Exerciner cost be notified at 1XYes 2 □ No Director Kent Chestertown MD 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? ō 21620 U.S.A. items 23a 200 Morgnec Road Funeral death v 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married ò If Yes, Give Year or Dates 1 Yes 2 No Specify: 2 Specify: Black 3 ☐ Widowed 4 X Divorced "natura!" Completed traumatic event, the Madical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Never Worked 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) []NK UNK Be ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any Injury or other trauonce. Barry Barrell/ Guardian Schauber Road, Chestertown, MD 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4
☐Donation 5 ☐Other (Specify) Anatomy Gifts Registry 8/26/2009 Hanover, Maryland 22. Name and Address of Facility Anatomy Gifts Regisrty 21. Signature of Funeral Service Licen 7522 Connelley Dr., Ste.P, Hanover, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Spnset and Death Immediate Cause (Final Alzheine **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Due to (or as a consequence Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examine sequende Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Y21 1 ☐ Yes No DX 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has birector, page 2 sl autopsy performed? 2 110 1 □ Yes 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending ours after death.

neral Director: Af
filled in by the fur 1 □Yes 2 □ No 2 Accident investigation 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

completely

Medical

(Check only one)

29b. Signature and title

of certifier

Frederick Delboy M.D.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0051735

6602 Church Hill Rd Ste. 200, Chestertown, MD 21620

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** emar /Medical County of Death **Examiner** 4b. City, Town, or Location of Death Haltimore Haspice lowson If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min 1 □ M 2 💢 F Yrs Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination that the profitted at 1 ☐ Yes 2 No Director Ma Woodstock 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Hernwood Koad USA 21163 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Completed by Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) pervisor Disabled 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) Be Minnie Grown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3510 Daughter Hernwood 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 ☐ Cremation 3 Removal from State West Chester, PA Rolling Green 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Lice Vaughn C. Greene 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
A Months Immediate Cause (Final disease or condition resulting in death) letastati **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner but to (or as a consequence of): To the Hospital or Attending Physlcian: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☑No 24a. Was an After this certificate has autopsy 2 No 1 ☐ Yes filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) \(\text{105} \) \(\text{105} \) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director; 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier nd address of person who empleted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-06577 State of Maryland / Department of Health and Mental Hygiene Shawn Jones 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death nt's Name (First_Middle Last Physician/ Month Day August 22, 2009 Year 0939 hrs **Medical Examiner** c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number **Baltimore County** Catonsville 7931 Eastdale Road 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 24Hrs. 5. Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year **Funeral** Min Months Days Hours Director 2 Yrs Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County IOc. City. Town or Location Yes 2 No 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f she is rother traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 14 Race - American Indian, Black, Status White, etc. Never Married 2 No Yes If Yes. Give Yea Yes 2 No specify: 3 Widowed Divorced ģ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 ne (First, Middle, Maider rst Middle Last) Be 19b. Mailing Address 20b. Place of Disposition (Name of cemet crematory or other place) Cremation 3 Important: I injury or oth Other Specify vice License Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or Physician Between Onset and failure. List only one cause on each line /Medical Death Pneumonia Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial - tran Physician/Medical 23a,27,perME g896 10/6/09 TT XUNPENDED AMENDED Box 68760. 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. <u>۾</u> 1 Yes 2 No 3 Probably 4 V Unknown Completed s been si 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has performed' death? After this certificate har funeral director, page 2 2 No 1 🗸 ✓ Yes 2 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be examiner? Other 4 Residence 6 V Other: Scene Inpatient ER/Outpatient 3 DOA Nursing Home 5 ၀ 1 🗸 Yes No 28a. Date of Injury (Month, Day,Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death Certification: 1 X Natural 1 Yes 2 Pendina within 24 hours after death.

To the Funeral Director:
completely filled in by the fi Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide (Specify) Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number August 23, 2009 O.C.M.E. 30. Name and odres of poor on who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Pamela E. Southall, MD 31. Date filed (Month, Day, Year) AUG 2 7 2009 32. Registrar's Signature State Registra

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ORIGINAL

DUME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-06362 State of Maryland / Department of Health and Mental Hygiene 2009 27455 Dante Kearney 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Month Day August 13, 2009 Physician/ 2350 hrs Medical Examiner Donte L. Kearney 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's 4103 21st Avenue Temple Hills 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. 5. Social Security Number 6. Sex If Under 1 Year 7. Age (In yrs, last birthday) **Funeral** oreignDetroit, Min Hours Months Days Director 380-08-3641 08/28/1987 1 XM 21 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State ij 1 X Yes 2 No or 28a-f show MD Prince Georges Bladnesburg items 23a or 28a-f sho ust be notified at once. hours after death with the Maryland Director 10f. Zip Code 10g, Citizen of What Country 10e Street and Number 20710 USA 4004 Roy Place Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married 2 X No 9 2X No specify Widowed Divorced Give Yaar Specify: Black Pages I and 2 should be filed within 72 hours after neut of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner þ 6b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) timore, MD 21215-0036 Student Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Tonya Kearney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 004 Roy Place 19a. Informant's Name/Relationship (Type, Print) Tonya R. Kearney/Mother Bladnesburg, 20710 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery. crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 8/21/09 Brentwood, MD Fort Lincoln Cem. Other Specify: Donation 5 0 22. Name and Address of Facility Austin Royster Funeral Home 21. Signature of Fur Service Licensee M00996 14th Street, N.W. Washington, DC 20011 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and **Physician** flure. List only one cause on each line /Medical Death a. Gunshot Wounds (2) to the Head Immediate Cause (Final disease taminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Undarrying Cause Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and - transit hysician/Medical UNPENDED AMENDED ned by the attending physician detached for use as the burial Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Live birth Fetal death past 12 months Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? ᅙ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. ₽ Yes 2 ✓ No 3 Probably 4 Unknown Completed page 2 should peen 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has b death? performed? ✔ Yes 2 No 1 🗸 Yes 2 Nο certificate 26.Place of Death (Check only one) 25. Was case referred to medical director, Be examiner? Hospital: 1 Nursing Home 5 Residence 6 V Other: Scene ER/Outpatient 3 Inpatient 2 After this 1 Yes ို 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury Subject shot Aug 13, 2009 2336 hrs Natural Yes 2 V No Pending To the Funeral Director: the 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 4103 21st Avenue, Temple Hills, MD determined (Specify) Driveway 4 V Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. g Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

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State Registrar 111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32 Registrar's Signatur

Ling Li, MD

31. Date filed (Month, Day, Year)

O.C.M.E.

August 14, 2009

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		-	For State Registrar	State of Iviary	•	rtificate of L			eg. No. 🤈 🖺 🖺 🧕	27457
	Physici	an	1. Decedent's Name (First, Middle, Last Edna V.) King				2. Date of Deat	23, 2009 Year	3. Time of Death 5:00 A. M
1	/Medic		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. County of Dear	
			Goldencrest Assis			Hampste	ad If Under 24 Hrs.	8. Date of Birth	Carro	oll thplace (State or Foreign
	Funeral Director		5. Social Security Number 215–18–7211 Usual Residence of Decedent	х Эм 2 X F 88	yrs. last birthday) Yrs.	Months Days	Hours Min.	July 9,	Year) Co	ryland
	yland now		10a. State 10b. County	100	c. City, Town or Lo	cation				10d. Inside City Limits
	Sa-fst	Director	Maryland Carroll		Hamps					1 □ Yes 2 No
	th with th		10e. Street and Number 1811 Albert Rill	Road		10f. Zip Code 2107			0g. Citizen of What Co	
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Mydical Evations, until be inclined a	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 XX N/Vidowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 □Yes 🎎 No	ispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Ame Black, Whit SpecifyWhi	e, etc.
5-0	72 ho "natui	Completed	15. Decedent's Edi (Specify only highest grad	ucation de completed)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of work	king	16b. Kind of Business	/Industry
121	within iene. than	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)	me.	Homemake			Own Hom	e
nd 2	al Hyg I other	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle,	Maiden Surname)	
yla	ould by Ment	To	Winfield Talbo		401 14-11	A daluna . /Chronk		a Morris	r, City or Town, State,	Zip Code)
Mai	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic		19a. Informant's Name/Relationship (7 Leonard King S	ype. Print) Son		-			ter, Maryl	
Baltimore,	ges 1 and 2 it of Health it If item 27 I or other tra		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Pamoval from State	Ob. Place of Dispo cemetery, crei	osition (Name of matory or other place	ce)	Date	20c. Location - City or	Town, State
tim	permit. Pages 1 Department of H Important: If ite any injury or of		4 ☐ Donation 5 ☐ Other (Specify	28/2009	Phoenix, Ma	aryland				
Bal	Deparent Important in any in		21. Signature of Funeral Service Licen:	B. Den		2. Name and Addre Burgee-He 3631 Fall		Funeral	l Home, Ind e, Maryland	21211
			23a. Part 1. Enter the disease, or compositors, or heart failure. List only of immediate Cause (Final	olications that caused the one cause on each line.	death. Do not en	iter the mode of dylin	ng, such as cardiad	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a co			V = 3 + 111	11307		Lyears
	Examiner	<u>.</u>	Sequentially list conditions,	b Due to (or as a co	insequence of):					
	suted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
0,	tificate be executed ig physician and as the burial-transit		resulting in death) Last	Due to (or as a co	ensequence of):					
68760,	rtificate b ng physic as the b	edical		d						
O. Box	Physician: The law requires that the death certif r this certificate has been signed by the attending ral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	☐ Ectopic pregnand☐ Other (specify) _	су		23d. Date of d Month	elivery Day Year
ds, P.	w requires that is been signed by should be deta	by	Part II. Other significant conditions of	ontributing to death but no	ot resulting in the u	underlying cause giv	en in Part I.		obacco use contribute ∕es 2 ☐ No 3 ☐ !	
Records,	The law req ate has beer age 2 shou	Completed						24a. Was autor perfo 1 □Yes	osy prior to rmed? death?	
Vital	ician: The certificate rector, pag	Be C	25. Was case referred to medical examiner?	11		Ott		ath (Check only o		
of \	ling Physi After this of funeral dire	2	1 ☐ Yes 2 ☐ Mo 27, Manner of Death	Hospital: 1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatie	ent 3 🗆 DOA			dence 6 Other (Sp how injury occurred	pecify)
ion	Attending r death. ector: After by the fune	ation	1 ☐ ¶atural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Ye	ear) Injury		rk?]Yes 2 □No			
Division of	al or Attend s after death. I Director: /	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (5	- At home, farm, si Specify)	treet, factory, office		28f. Location (3 City or Tox	Street and Number or with the state of the state)	Rural Route Number,
7	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exar	ysician: To the best of miner: On the basis of ex and manner stated	amination and/or i	ath occurred at the t investigation, in my	ime, date and plac opinion, death occ	e, and due to the urred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	To the within To the complex c	Ž	29b. Signature and title of certifier	MO		29c. Licen	se number		Aug 2	nth, Day, Year)
_			30. Name and address of person who	completed cause of death	torev Au	e, Print) enue	MO	21157	-	
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	backer				

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			1 - For State Registrar	State of	Marylar		artmen rtificat				lental Hy	giene Reg. No.	009	27458		
	Dhi.		1. Decedent's Name (First, Middle, Las	t)							2. Date of De	ath Day	Year	3. Time of Death		
	Physici /Medi		Virgin	ia Erne	stine	Krouse					Augus			6:00 A M		
	Examir		4a. Facility Name (If not institution, give	street and num	ber)		4b. City,	Town, or	Location of	of Death		4c. (County of Dea	ith		
			3136 Cornwall H					Dund					Baltin			
и	Funeral		5. Social Security Number 6. Se	9X 7 □M 2⊠F		. last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	y, Year)	9. Bir	rthplace (State or Foreign ountry)		
	Director		175-20-6285 Usual Residence of Decedent		84	113.					Jan. 1	7,192	25 P	ennsylvania		
	yand ow		10a. State 10b. County		10c. C	ity, Town or Lo	cation							10d. Inside City Limits		
	Man ii	to	Maryland Ba	ltimore					Dund	lalk				1 ☐ Yes 2X No		
	r 28g	Director	10e. Street and Number				10f. Zip	Code				10g. Citiz	en of What C	ountry?		
	23a c		3136 Cornwall R	load				2	1222			Uni	ted St	ates		
	72 hours after death with the Maryland natural', or Itams 23a or 28a-1 ahow idical Examinar must be notified at	Funeral	11. Marital Status	12. Was Deced	lent Ever in U	J.S. 13.	Vas Deced	lent of Hi	spanic Ori	gin? (Sp	ecify Yes or No Rican, etc.))- 1	4. Race - Am Black, Whi			
36	or it	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 If Yes, Give	No		1 ☐ Yes		Specify:		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Specify:			
Š	ural,	d by	3X Widowed 4 □ Divorced	Year or Dat	les:									White		
5	n 72 n	Completed	15. Decedent's Ed (Specify only highest grad			16a. Deced	dent's Usua kind of woi DO NOT us	rk done o	lurina mos	t of work	ing	16b. Kin	nd of Business	s/Industry		
12	within ene. then "	Ę.	Elementary/Secondary (0-12) 12 Years	College (1-	4or 5+)		sewif	•	,				vn Home			
2	Hygi ther	ပိ	17. Father's Name (First, Middle, Last)	-		tron	SEMIT	-	18. Mothe	r's Nam	e (First, Middle					
a	D 9 2 0	To B	Andrew Strave	rs					As	nes	Folows	ka	,			
Maryland 21215-0036	2 shoul and M is mari	-	19a. Informant's Name/Relationship (7			19b. Mailir	ng Address	(Street a			al Route Numb		Town, State,	Zip Code)		
	- C - M		Mr. Dennis Krouse	(So	n)	181	7 Jac	kson	Road	l Di	undalk,	Mary	land 2	21222		
J.	of Health Itam 27 cother t		20a. Method of Disposition			Place of Dispo	sition (Nan	ne of ther place	9)		Date	20c. Loc	ation - City or	r Town, State		
Ĕ	Page nent of Iny or		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		ate		-		-	Com	8/27/2	009	Dorse	v. Maryland		
Baltimore,	permit. Pages i Depertment of I Important: If Ita any injury or ot once.		1. Signature of Paneral Service Likensee 22. Name and Address of Facility 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk Inc.													
_	89 E 2 9		22 Name and Address of Facility Duda–Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate													
	Physician /Medical Examiner burial-transit sthe burial-transit	Ical Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (o	r as a consecutar as a consecu	epsis quence of): ry tr quence of):	ract							Interval Between Onset and Death		
P.O. Box 68	Physician: The law requires thet the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₹ No 9 □ Unknown	_	th 2 ☐ Feta ntattime of d	aldeath 3	Ectopic pro					2	3d. Date of de Month	olivery Day Year		
S, F	gned I	by P	Part II. Other significant conditions co				nderlying ca	ause give	n in Part I.		23e. Did t	obacco us	se contribute t	o the cause of death?		
Records,	equir en si ould I	bed	/t/zheimer	's aer	nenti	a					10	Yes 2□]No 3 ☐ P	robably 4 Minknown		
မွ	hasbe pe2sh	Completed									24a. Was		24b. Were a	utopsy findings available completion of cause of		
<u> </u>	The gate h	Con										rmed?	death?	s 2□No		
/ita	cian: ertific actor,	Be	25. Was case referred to medical examiner?					-		of Deat	h (Check only o	опе)		. 44-1		
\leq	hysi his o	ဥ	1 ☐ Yes 2 ☑ No	Hospital: 1 🔲 Ing	oatient 2] ER/Outpatien	t 3□ DO	A Othe	r: 4 □ Nu	rsing Ho	me 5 Resi	dence 6	□Other (Spe	ecify)		
ב	ing P	on:	27. Manner of Death 19≦Natural 5 ☐ Pending	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury	-	Bc. Injury Work	at		28d. Describe	how injury	occurred			
Sign	Attanding ir death. actor: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be				М		/es 2 □ I	No						
=	or Al efter of Dirac in by	Certification:	4 Homicide determined	28e. Place o	g, etc. (Special	ome, farm, str fy)	eet, factory	, office			28f. Location (Street and wn, State)	Number or A	lural Route Number,		
_	a Hospital 24 hours e a Funeral C letely filled i		29a. Certifier 15 Certifying Phy	sician: To the b	est of my kno	owledge death	Occurred :	at the tim	e date an	d place	and due to the	201120(2)	and manner o	a stated		
1	24 h 24 h E Fur	edical	(Check only 2 Medical examone)	ner: On the bas	is of examina	ation and/or inv	estigation,	in my op	inion, dea	th occur	red at the time,	date and	place, and du	e to the cause(s)		
. 1	To the Hospital or Atlanding Physician: The I within 24 hours effer death. To the Funeral Diractor: After this certificate ha completely filled in by the funeral director, page	Me	29b. Signature and title of certailer				29c	. License	number			29d. Date	signed (Mon	th, Day, Year)		
	2. 3		· 1/2//	-3.0				Hn	044	170	6	Au	sust 2	5,2009		
			30. Name and address of person who c	ompleted cause	of death (Iter	m 23a) (Type,	Print)	110	-			1 1 2	100	-, 2009		
_			705 Digital	Drive, J	rufe G	ature	Maio	um,	MD	21	090					
	Sta		31. Date filed (Month, Day, Year)	32. Rec	gistrar's Signa	ature 4	del									
	Registr	ar	AUG 2.7 200	y Clark	me for	1. 1490	1									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 23, **Physician** August 2009 10:30 A M Alicia F. Kousouris /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Lutherville 65 Belmore Road 9. Birthplace (State or Foreign 8. Date of Birth 06-26-1917 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Marvi and 1 □ M 2 🖫 F 92 216-32-3795 Director Usual Residence of Decedent illed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Evantinar must be notified at 1 ☐ Yes 2 M No Director Lutherville Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21093 65 Belmore Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∏Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: White þ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Annie Kelly James J. Finnegan ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Georgia Angelos - Daughter Monkton, MD 21111 16450 York Road Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08-26-2009 Baltimore, Marvland Parkwood Cemetery 22. Name and Address of Facility 21. Signature Funeral Service Cens 5305 Harford Road harlos Leonard J. Ruck, Inc. Baltimore, MD 21214 mer 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 125 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the a 9 I Unknown s been signed b should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 Tyes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has page 2 s autopsy death? 1 ☐ Yes 2 ☐ No Hospital or Attending Physician; The 1 ☐ Yes After this certification funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Stertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0018662

State Registrar 31. Date filed (Month, Day, Year)

120 SR. PIRRAR In.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600

			1 - State of Ma State of Ma Registrar	-	artment of Health and N rtificate of Death	Aental Hygie _{Reg.}	2000	27460
	Physic	an	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	/Medi		Bertha D. Kryger			August	26,2009	5:15a ^M
	Examir	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death		
	Funeral Director		Belair Health & Rehab	e (In yrs. last birthday)	Bel Air	8. Date of Birth	Harfor	
			217-05-8599 1 M 2 F	92 Yrs.	Months Days Hours Min.	Sept21,	1917 Man	pplace (State or Foreign intry) ryland
	fand ow	Completed by Funeral Director	10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits
	Mary Frsh		Md. Harford	Aberde	en			1 XYes 2 ☐ No
	vith the Maryland or 28a-f show		10e. Street and Number		10f. Zip Code	10g	. Citizen of What Cou	intry?
	s 23a or		6 Market Street		21001		U.S.A.	
Baltimore, Maryland 21215-0036	ours after de ral", or item Eval. item		11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced 12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No I	Was Decedent of Hispanic Origin? (Sy If Yes, specify Cuban, Mexican, Puerto 1 □Yes 2 No Specify:	pecify Yes or No- Brican, etc.)	14. Race - Amer Black, White Specify: Wh:	, etc.
5-	"natu	lete	15. Decedent's Education (Specify only highest grade completed)	ı (Give	dent's Usual Occupation kind of work done during most of work	king	b. Kind of Business/I	ndustry
12	withir ene. than	ğ	Elementary/Secondary (0-12) College (1-4or 5	+) .	ine Operator	Δ	merican	Can Com.
9	filed Hygi other ent,	To Be Co	17. Father's Name (First, Middle, Last)			e (First, Middle, Mai		Can com.
lan	ld be lental ked c		John Domowski		France	s Franko	wski	
ary	2 should be filed within and Mental Hygiene. is marked other than aumatic event, the Man	-	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street and Number or Ru	ral Route Number, C	City or Town, State, Z	ip Code)
Σ	and 2 ealth n 27 i		Mrs. Frances Clark/Daug	shter 154	Leona Drive Co	nowingo,	Md. 219	918
ore	ges 1 and 2 should be filed within 72 hc to Health and Mental Hygiene. If item 27 is marked other than "natur or other traumatic event, the Medical		20a. Method of Disposition → Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Dispo	sition (Name of instruction of the state of instruction of the state o	Date 20	c. Location - City or T	Town, State
Ë	Pag tment tant; I		4 Donation 5 Other (Specify)	1	sary Cem. 8-28			•
Ball	permit. Pages 1 and 2.9 Department of Health a Important: If item 27 is any Injury or other trau		21. Signature of Funeral Service Licensee		2. Name and Address of Facility Kac 201 Dundalk Ave			
	23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) The property of the disease or condition resulting in death) Due to (or as a consequence of):						i,	Approximate Interval Between Onset and Death
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	a consequence of):				
V	cuted nd ransit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as					
68760,	rtficate be executed ng physician and as the burial-transit	I Ex	resulting in death) Last Due to (or as	a consequence of):				
876	cate b	edical	d					
O. Box	ath cer ttendin or use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑No 9 ☐ Unknown 23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of deli Month	very Day Year
٠ <u>.</u>	quires that the de en signed by the a uld be detached f	y Ph	Part II. Other significant conditions contributing to death be	ut not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
rds		ed by	Alzheimer's demention	a		1 ☐ Yes	2 No 3 □ Pr	obably 4 🗆 Unknown
Records,	sician: The law requir certificate has been s irector, page 2 should	Completed				24a. Was an autopsy performe	prior to d	topsy findings available completion of cause of
tal	ificate		25. Was case referred to medical		00 81(18	1 □Yes 218		2 🗆 No
of Vital	ysician: iis certific director,	o Be	examiner?	ent 2 ☐ ER/Outpatier	0.11	th (Check only one)	ce 6 ☐ Other (Spec	26.0
J Of	ting Phy J. After thi funeral of	n: T	27. Manner of Death 28a. Date of Inju	ry 28b. Time of		28d. Describe how		спу)
jor	Attending r death. ector: After by the fune	atio	1 Natural 5 □ Pending (Month, Dag 2 □ Accident investigation	y, Year) Injury	M 1 ☐ Yes 2 ☐ No			
Division	al or Attendi after death. I Director: A d in by the fu	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Initial building, et	ury - At home, farm, strop. (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
À	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Chack only one) 1 Certifying Physician: To the best of the desired properties o	f examination and/or in	h occurred at the time, date and place vestigation, in my opinion, death occu	, and due to the cau rred at the time, date	ise(s) and manner as and place, and due	s stated. to the cause(s)
ク	To the He within 24 To the Fu	Me	29b. Signature and title of certifier	D -	29c. License number 7 006 3981		Date signed (Month	
			Benjamin Lee, MD 6	69 Revol	ution St., Ha	vre de G	race Mi	21078
	Sta		31. Date filed (Month, Day, Year) 32. Degistro	ar's Signature	- 4.1			
	Registi	ar	AUG 27 2009 Peneu	N B. B.	aver			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year LAWSON C. LAWS 08 2009 26 8:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2735 ROUND ROAD BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 XM 2 ☐ F Days Hours Yrs. Director 217-16-0044 90 06-02-1919 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar inust be notified at MD BALTIMORE Director 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2735 ROUND ROAD 21225 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. e filed within 72 hours after or all Hygiene. other than "natural", or iter 1 Xes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 þ 1 □Yes 2 □XNo Specify: BLACK 3 Widowed 4 □ Divorced WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **STEVEDORE** SHIPPING_INDUSTRY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLES Ρ. T.AWS P KATHLEEN BOYER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health as
Important: If Item 27 is
any injury or other trau ALGERIA TATE/NIECE 7266 MANDAN RD., GREENBELT, MD 20770 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State FIRST BAPTIST 4 Donation 5 Dother (Specify) CEM. 08-30-2009 HEATHSVILLE, VA 22. Name and Address of Facility JAMES A. MROTON & SONS F.H., INC 21. Signature of Funeral Service Licenses 1701 LAURENS ST., BALTIMORE, MD 21217 23a. -rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** myocardia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🔲 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ CHF1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 █ Unknown DM 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 7 1 ☐ Yes

Box 68760. P.0. Division of Vital Records, death.

25. Was case referred to medical examiner? 27. Manner of Death

1∐ Yes 2X No

Natural 2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

SHARON

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

AUG 27

Completed Be Certification: To

Medical

To the Hospital or Attending I Director: / hours after within 24 hours a

> State Registrar

Balanson Anaron

2009

5 Pending investigation

6 ☐ Could not be

determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28a. Date of Injury (Month, Day, Year)

D0055157

Greene

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

St

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Sesidence 6 Other (Specify)

Baltimore

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year) 271

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Year

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BALANSON 10

32 Registrar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #5, per FH G896 10/1/09 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 11:05A M DUGUST 25 MANIE Long /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Co. Manchester Longview Nursing Home 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, Social Security Numbe 213-16-5824 **Funeral** Days Min Maryland 1 ☐ M 2 🖾 F 87 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or forther traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Director Maryland Baltimore Dunda1k 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number United States 21222 Funeral 7518 Carroll Avenue 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 XI No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No 3altimore, Maryland 21215-0036 Specify. White þ 3 Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 Years Bakery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henrietta Blishee ပ Herman Yeager 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7518 Carroll Ave. Dundalk, Maryland 21222 (Son) Mr. John L. Long 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition NSBurial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 4 ☐ Donation ≠ 5 ☐ Other (Specify) Oak Lawn Cemetery 8/27/ 2009 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Funeral Service Liceps Inc. 21222 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine. Immediate Cause (Final disease or condition resulting in death) ANTILIOSCISLOTIC VOSCULAR DISTASE **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) attending physician for use as the buria Division or Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy nertorm 1 ☐ Yes 2 ☐ No 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

**Thrush C. Sinker 25 Minis Start #500 Reisensow, Mary Inw 21134

31. Date filed (Month, Day, Year)

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State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

M.D. 4940

32. Registrac's Signature

Registrar DHMH 17 Rev 1/2001

State

Division of Vital Records, P.O. Box 68760,

Marke

			Amend #8 per Fit G895 9/1//09 TT State of Maryland / Department of Health and Mental Hygiene - For Amend Items 2,25 pr dr., 8894,08/27/09dhb Certificate of Death - Reg. No. 2009 2746	1
X.S	Physici		State Registrar Certificate of Death Reg. No. (1009 (100) Decedent's Name (First, Middle, Last) CARL MERET Reg. No. (1009 (100) CARL MERET Certificate of Death Reg. No. (1009 (100) Act Cost (100) Reg. No. (1009 (100) Act Cost (1
and a	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4d. County o	an .
	Funeral Director		5. Social Security Marriage 1. Security Marriage 1. Security Months Days Hours Min. Month, Day, Year 04 Country) O76 54-13C 1 12 M 2 F 6 Yrs. Months Days Hours Min. MARCH 3 1948 Trinidad Usual Residence of Decedent	
and 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Medical Examination of the traumatic event, if a Medical Examination of the continual particle of the continual particle of the continual particle of the continual particle of the continual once.	Be Completed by Funeral Director	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limit 1 Yes 2 N 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	_
			1435 6 esna Dr 21076 USA	
			11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes, Specify: Specify: Specify:	
			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Wolder 16b. Kind of Business/Industry (Give kind of overk done during most of working life. DO NOT use retired) Wolder	zn'
			17. Father's Name (First, Middle, Last) Creary Merez 18. Mother's Name (First, Middle, Maiden Surname) Flaine Giftens	~ (
Maryland		To	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1435 Gesna Dr. Hanover, Mb 21076	
Baltimore,			20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 8-32-09 ELVICE WO 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility	Si
O. Box 68760,	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burtal-transit	d by Physician/Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Mailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 5 Other (specify)	
σ.			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Unknown	
of Vital Records,	The law rec cate has bee page 2 shou	Completed by	24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No	ble of
Vita	Attending Physician: The law r death. sctor: After this certificate has by the funeral director, page 2 s	Be C	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)	
Division of		Medical Certification: To	27. Manner of Death 1 Matural 5 Pending (Month, Day, Year) 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? M 1 Yes 2 No	
Divi	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide determined building, etc. (Specify) City or Town, State) 29a. Certifier 1 ertifying Physician: To the best of my knowledge_death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
5	To the Ho within 24 h To the Fu completely		(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of gertifler 29d. Date signed (Month, Day, Year)	_
)			CARLOS N. 84 THLINGHOLG SCAND P18476 ACIGUST 17, 2009 30. Num. and address of person who completed cause of death (Item 23a) (Type, Print) 3734 POTET SI. BALI. NO 21225	
	Sta Regist		31. Date filed (Month, Day, Year) 31. Registrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 16 55 PM JOHN CHARLES MAGEE 2 8 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Rosedaly FRANKLIN SQUARE HOSPITAL CENTER BalTimore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth Month, Day, Year) June 9, 1944 7. Age (In yrs. last birthday) **Funeral** Days Hours XXM 2□F Min. 216-44-0887 Mary Tand Director 65 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Evantment or other traumatic event, the Modical Evantment or other traumatic event, the Modical Evantment. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2XXXVo Director Baltimore Baltimore County Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 USA 2121 Rocky Point Rd. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes XX No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes XX No Specify: Specify: White 3 ☐ Widowed 4 🙀 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Flementary/Secondary (0-12) College (1-4or 5+) Graphic Artist National Graphics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rebecca Zengel Charles Andrew Magee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ryan J. Magee (Son) 1818 Earl Drive Bel Air, Md. 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Metro Crematory, Inc. 8-29-2009 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Linensee 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 Hou BOM 23a. Part 1. Enter the diseas or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Coronary syndrom /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Congestive HearT Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? melliTus 24a. Was an performed 2 No Division of Vital 1 ☐ Yes 1 ☐Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 ☑ Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20054 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NONA NOVELLO 9000 FRANKLIN Square DR Balt md

Registrar

31. Date filed (Month, Day, Year)

AUG 27 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Z U U S Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Year Physician 6:10 PM 2009 John Vincent McFeaters /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Franklin Square Hospital Kosedale Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min. 1**X** M 2□ F Hours Mar. 25, 1944 Maryland Director 214-40-0690 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Maryland Dunda1k Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States by Funeral 7940 St. Bridget Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No 11. Marital Status 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify. 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Manufacturing Electrician 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary F. O'Donnell John G. McFeaters 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dundalk, Maryland 21222 (Wife) 7940 St. Bridget Lane Judy Ann McFeaters 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State 8/25/2009 4 ☐Donation 5 ☐ Other (Specify) Baltimore, Maryland Oak Lawn Cemetery 22. Name and Address of Facility neral Servic Icen e Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cancer /Medical Due to (out a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by tastasis/Pneumococcal Pneumonia 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2 No To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1X Natural 2 Accident Iniury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Medical

Hospital or Attending Physiclan: The law requires that the death certificate be executed Box 68760 Division or Vital Records, P.O. within 24 hours are.

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permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be n

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and the of certifier 29c. License number 027356 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square Drive, Baltimore, Maryland 21237 32. Registrar's Signature WMC WATERFIELD 31. Date filed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year illie : ISPM 1900 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Bupiers Core Ontes 130/14/2 adtio 2000 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 □ F Director 214-40-3323 69 Oct.31,1939 N. Carolina Usual Residence of Decedent the Maryland 10a. State 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f shows the Medical Examinator at the Medical Examinator at the motified at Director 1 Yes 2 No MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit, Pages 1 and 2 should be filed within 72 hours after death with 1 Department of health and Mental Hygiene, Important: If Item 27 is marked other than "natural", or items 23a nr? once. 4619 Furley Ave. Funeral 21206 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐ Never Married 2 ☐ Married ⋛ Army 1 □Yes 2 □XNo Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Bus Operator MTA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٥ Oscar Newkirk Rosa Burney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Dubose-McCoy/Wife 4619 Furley Ave. Balto. Md 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) GarrisonForestVetCemSept1,2009OwingsMills, MD 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME e of Funeral Service Licens E. PRESTON ST. BALTO. MD 412 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** disease or condition resulting in death) Icchi /Medical Due to (or as a consequence Examiner Sequentially list conditions, any cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlar-transit resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of this certificate has al director, page 2 autopsy Periton 2 🗆 No 1 ☐Yes 2 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA $4 \square$ Nursing Home $5 \square$ Residence $6 \square$ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicíde 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

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	_	State Registrar Decedent's Name (First, Middle, Las	׆)	Ce	rtificate of I	Deam	2. Date of De	Reg. No.	ША	2/469
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Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Dea	th J.	4c. Cour	nty of Death	
		The Johns Hopkins H			Baltimore					
Funeral		5. Social Security Number 6. Social Security Number 12.14–11–3833	ex 7. Age (In yrs. 91	last birthday Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th ay Year)	9. Birth	place (State or Foreign
Director		Usual Residence of Decedent	-)	110.			05/25	/ 1918	Phi	llippines
yland now		10a. State 10b. County	10c. Ci	ty, Town or L	ocation					10d. Inside City Limits
a-f st	ctor	Maryland N/A	Ba	ltimon	æ					1 X Yes 2 □ No
or 28	Director	10e. Street and Number			10f. Zip-Code			10g. Citizen o	f What Cou	ntry?
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tems er mu	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13	. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (san, Mexican, Puer	Specify Yes or No to Rican, etc.)	- 14. R	ace - Ameri lack, White,	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 [XMarried 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes ② No If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:				llippino
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uld b Menta Irked tic ev	10	Rufino Ordanza				Antoni	ina Guer	rero		
2 sho and I is ma		19a. Informant's Name/Relationship (7	ype. Print)	19b. Mai	ling Address (Street				n, State, Zij	code)
and and a salth		Eusebia M. Ordanz	za - Wife	202	S. Regist	er Stree	et Baltin	more, M	aryla	nd 21231
Pages 1 and nent of Health int: If item 27 iry or other to		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		Place of Disp cemetery, cre	oosition (Name of ematory or other plac	ce)	Date	20c. Location	n - City or T	own, State
ment ment tant: jury o		4 Donation 5 Other (Specify) At		: Cremator		/28/09			, Maryland
permit. Departn Importa any injt once.		21. Signature of Funeral Service Licens		Í	22. Name and Addre David J. W 101 S. Che	ss of Facility Veber Fur Ester Sti	neral Hor reet Balt	mes P.A timore,	Mary	land 21231
		23a. Part 1 Enter the disease, or comp shoo, or heart failure. List only of	ation that as sed the deat						Ť	Approximate Interval Between
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	iner	Sequentially list conditions, it any hood stock to the cause. Enter Underlying	Danty (or as a consec	uerne diy						
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be executed ician and burial-transit		resulting in death) Last	Due to (or as a conseq	juence of):						
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ertific ing pl	/Me	IF FEMALE:	Ole Huse suterms of sever							
death certificates attending phy	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnant 1 Live birth 2 Feta	al death 3	Ectopic pregnanc	ey .			Date of deliv Month	very Day Year
hat the death d by the atte detached for	ysi	1 Yes 2 No	4 ☐ Pregnant at time of d 9 ☐ Unknown	leath 5	Other (specify)			ļ		
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The law requires that the death certificate the has been signed by the attending physipage 2 should be detached for use as the	d by		•				11	/ Yes 2 ☐ No	3 🗌 Pro	bably 4 🗌 Unknown
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sician; Tr certificate irector, pa	0	25. Was case referred to medical				26. Place of De	1 Yes ath (Check only o	2 🗌 No	1 🗌 Yes	2 ☑ 1√0
ysicia s cert direc	5 B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	ER/Outpatie	nt 3 DOA Oth	or.	fome 5 ☐ Resi		ther (Specia	fv)
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Attend r death ctor: /	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At ho	me, farm, st		Yes 2 □ No			mber or Rui	ral Route Number,
Hospital or Attending Physician; A hours after death. Funeral Director: After this certificately filled in by the funeral director.		·	building, etc. (Specifi				Cify or Tov			
To the Hospi within 24 hou To the Funer completely fil	edical	29a. Certifier 1 ☐ Certifying Phy (check only one) 2 ☐ Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, dea tion and/or i	th occurred at the tir nvestigation, in my c	me, date and place opinion, death occ	e, and due to the curred at the time	cause(s) and , date and plac	manner as e, and due	stated. to the cause(s)
om this	Me	29b. Signature and title of certifier		•	29c. Licenso			29d. Date sign	ned (Month,	Day, Year)
		MARINO) .		RES	000		03- 3	14-2	009

State Registrar

DHMH 17 Rev 1/2001

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Hallow &

31. Date filed (Month, Day, Year)

AUG 2 7 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 🗎 🗎 🔍 Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) **Physician** 2:58 A M 8/20/2009 Laurence Gerald Oursler /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carrol1 Westminster Carroll Hospice Dove House If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 100 M 2□ F Yrs. MD 78 03/29/1931 Director 218-28-5305 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City. Town or Location 10b. County 10a. State Hygiene. other than "naturel", or items 23s or 28s-f show ent, the Madical Examiner must be cultified at 1 Yes 2 No Funeral Director Manchester Carroll 10g. Citizen of What Country? 10e. Street and Number USA 21102 2021 Ebbvale Rd. death 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White, etc. filed within 72 hours after 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2K Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) John K. Ruff Co., Inc. Construction Supervisor 12 Uth and Mental Hyc 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Esther S. Berry Pages 1 and 2 should 0 Laurence E. Oursler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau 2021 Ebbvale Rd., Manchester, MD 21102 Margaret Oursler/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 8/20/2009 Winfield, MD Donation 5 Other (Specify) S. Carroll Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Burrier-Queen Funeral Home & Crematory, P.A. awy 1212 W. Old Liberty Rd., Winfield, MD 21784 ZUM 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheet or heart failure. List only one cause on each line. Onset and Death fmmediate Cause (Final disease or condition resulting in death) **Physician** Cardiomyopathy /Medical Due to (or as a consequence of): Examiner Chronic Alcoholism Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine be executed use as the burial-transit the attending physicien and P.O. Box 68760.⊄ Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Day ō in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown s been signed by the should be detached 23e. Did fobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulfing in the underlying cause given in Part I. Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Prostate Cancer Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy nerformed' 2 🗌 No 1 Yes certificate 1 Yes 2 🛛 No Division of Vital Attending Physician: 25. Was case referred to medical 26. Pface of Death (Check only one) Be Hospital: 1 Inpatient 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify Hospice 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending 1 Tes 2 No death. investigation 2 Accident al or Attend after death Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours af To the Funeral D 29a. Certifier 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 1384-30 0 nd address of person who completed cause of death (Item 23a) (Type, Print) Uggowitzer, M.D., 814 N. Houcksville Rd., Hampstead, MD 210/4 Peter G. 31. Date filed (Month, Day, Year)
AUG 2 7 2009 32. Registrar's Signature State AUG 2 arke Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 10:22 AM 4c. County of Death Glenn Lee Prichard quet 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Washington 107 High Street Hagerstown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 1 ★M 2 □ F 42 8/6/1967 219-88-9320 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 1 1 Yes 2 □ No MD Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 107 High Street 21740 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 1 ∐ Yes 2 [X]No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☒ No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Car Mechanic Automotive 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Glenn Watson Betty King 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 107 High Street, Hagerstown, MD 21740 Tiffany Prichard/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry 8/26/2009 Hanover, Maryland 4 ∑Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licer see 7522 Connelley Dr. Ste.P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) mou Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐ Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1□ Yes No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Inpatient 3 DOA 1 Tyes 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

/Medical Examiner Examine physicien and s the burial-transit Physician: The law requires that the death certificate be executed Records, P.O. Box 68760, Physician/Medical þ Completed Division of Vital After this certification funeral director, Be ို Certification; or Attending within 24 hours after death.

To the Funeral Director: All completely filled in by the fu Fo the Hospital

Physician

/Medical

Examiner

Funeral

Director

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permit. Pages 1 and 2 a Department of Heelth as Important: If Item 27 is eny Injury or other trau

Physician

the Medical Examiner must be notified at

Director

Funeral

Completed by

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with the Maryland

Medical 29n Carthur 29b. Signature and title of certifier

State Registrar

10mdan 31. Date filed (Month, Day, Year) BARA

AUG 27

2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

*** Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cruse(s) and channer as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2^{a} 3, 2009 8:20p M August Robert William Parker 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) N/A Baltimore 155 S. Grundy Street Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 5. Social Security Number Min. Hours Months Days 1 X M 2 □ F 8-10-1926 Maryland 83 212-22-0912 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 Ves 2 No N/A Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Grundy Street Apt 236 21224 155 S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No WWII If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16b Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Accounting Bookkeeper 18. Mother's Name (First, Middle, Maiden Surname) (UNK) 17. Father's Name (First, Middle, Last) (UNK) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5003 Cameo Terrace Perry Hall, MD 21128 Patricia Mulligan 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 8-28-09 Dundalk, MD 4 ☐ Donation 5 ☐ Other (Specify) Holy Rosary Cem 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee 1201 Dundalk Avenue Baltimore, MD 21222 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ischemic Heart Disease disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) 4 Pregnant at time of death □Yes 2□No 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗆 No 1 ☐ Yes 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 \sum Nursing Home 5 \overline{\mathbb{Q}} Residence 6 \subseteq Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 📉 No

Examiner that the death certificate be executed and burial-trar physician the attending pt P.0. signed to Division of Vital Records,

Physician

/Medical

Examiner

Physician/Medical

Certification: To

Medical

29a, Certifier

filled in by

within 2.

cate has to page 2 s certificate funeral After o the Hospital or Attendin thin 24 hours after death. The Funeral Director: Aft the

Physician

/Medical

Director

Funeral

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Completed

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Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Evanding must be notified at once.

Baltimore, Maryland 21215-0036

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29b. Signature and title of certifier

28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work?

27. Manner of Death 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide

> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
>
> X CRNP and manner stated. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

> > August 26, 2009

ted cause of death (Item 23a) (Type, Print) 30. Name and address of person w

3901 The Alameda Baltimore, MD 21218 Lee, Janet⊬ CRNP 32. Registrar's Signature 31. Date filed (Month, Day, Year)

k war

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2009 11:48 A George August Rose Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Towson If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 € M 2 □ F Months (Month, Day,) Aupust 23 Year Country Director 218-44-1004 Greece Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 🗆 Yes 2 🖵 No Cockeysville Maryland Baltimore 10e. Street and Number 10a. Citizen of What Country? Funeral 21030 USA Apt. 201 2 St. Elmo Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: White Completed 3 Widowed 4 Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Restauranteur n/a Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Filanthi Kivelou George Routzounis and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sh tment of Health a tant: If item 27 is 3136 Eden Drive Abingdon, Maryland 21009 Mr. Steve Rose (Son) DateUNK 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation Other (Specify) Melea-Kalamon-Messina Other (Specify City Cemetery Common 21204 21. Signatur 22. Name and Address of Facility 1050 York Road Towson, Md. Ruck Towson Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final) Physician/ ancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ate has been signed by the atte page 2 should be detached for Month Day Year 5 Other (specify) Pregnant at time of death 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has autopsy performed? Yes 2 No 2 🗆 No 1 Yes To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certification of the funeral director, the funeral director, to the funeral director, the funeral director, the funeral director, the funeral director, the funeral director director, the funeral director director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death
1 Natural
2 Accident 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Tes 2 🗌 No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Sign 29d. Date signed (Month, Day, Year) 9810c 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles St zushmb 6701 32. Registrar's Signatur

Registrar

AUG 27

		State of Maryland / D					
	•	For State Registrar	Certificate of			J. No.	27475
Physici	an	1. Decedent's Name (First, Middle, Last)			Date of Death Month	Day Year	3. Time of Death
/Medic	cal	Marko Robert Radakovic, Sr.	4b City Town	or Location of Death	August	25, 2009 4c. County of Death	9:00 A ^M
Examin	er	4a. Facility Name (If not institution, give street and number) 2840 Ritchie Ave.		emere			ore Co.
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bir	thday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,	Year) Cou	place (State or Foreign intry)
Director		213-07-1446 89	Yrs.		Feb. 7,1	920 Ohi	0
land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	n or Location				10d. Inside City Limits
Mary a-f sh	ctor	Maryland Baltimore	Ed	gemere			1 □ Yes 2 No
or 28	Director	10e. Street and Number	10f. Zip Code	01010		g. Citizen of What Cou	
within 72 hours after death with the Maryland within 72 hours after death with the Maryland isine. than "natural", or items 23a or 28a-f show the Modical Evaminar must be Indiffed at	eral	2840 Ritchie Avenue 11 Marital Status 12. Was Decedent Ever in U.S.	13 Was Decedent of	21219		United St	
fter de	Funeral	1 Never Married 2 Married WXYes 2 1-No	13. Was Decedent of If Yes, specify Cul		Rican, etc.)	Black, White	
5-UUSO 72 hours aft natural", or	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: WWII	1 □Yes 2 🛣 No	Specify:		Specify:	White
"natu	Completed	15. Decedent's Education 16a (Specify only highest grade completed)	Decedent's Usual Occu (Give kind of work done life. DO NOT use retin	during most of work		6b. Kind of Business/li	ndustry
Z I Z I Z within giene. Ir than "	d w	Elementary/Secondary (0-12) College (1-4or 5+) 9 Years		Foreman		Pipe Fitt	er
and defined and be filed ental Hyge ced other cevent, I	Be C	17. Father's Name (First, Middle, Last)	00110101	18. Mother's Name			
ylan	2	Anton Radakovic			Alice Buk		
DESILITION CE, INIGITY JAING ZIZIO-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinet must be notified at once.			. Mailing Address (Stree 1520 Leslie		ai Houte Number, nda1k,Ma		.222
re, I	1		f Disposition (Name of ry, crematory or other plants			Oc. Location - City or T	
SAILLIMOF Dermit. Pages Department of mportant: If it any injury or o		1 LX Burial 2 Li Cremation 3 Li Removal from State	t Lutheran	i	3/2009	Baltimore,	Marvland
Dalti permit. Departh Importa any inju		21. Signature / Furieral Service Licensee	22. Name and Add Duda-Ruc	ress of Facility k Funeral	Home of	Dundalk, I	nc.
		Direga C. Ku	7922 Wi	se AveD	undalk.	Maryland 2	1222
		23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dy	/ing, such as cardiac	or respiratory arre	o.,	Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death) a. Due to (or as a consequence		Cancer			14 years
Examiner							
sit ed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	of):				
te be executed ysician and e burial-transit	Exan	that initiated events resulting in death) Last C. Due to (or as a consequence	of):		·		
te be exergistion and burial-	ca	d					
BOX 587 (leath certificate leath certificate leath or use as the box 150 use as the box	Physician/Medi	if FEMALE:	-				
death ce attendii	lan/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1	n 3 ☐ Ectopic pregnar 5 ☐ Other (specify)			23d. Date of del	Day Year
the d	hysic	1 Yes 2 No 9 Unknown					
ecords, P.O. law requires that the de as been signed by the 2 should be detached	by P	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause o	given in Part I.	11	acco use contribute to	
ecord law requir as been si 2 should b							obably 4 Unknown
~ • • •	Completed				24a. Was an autopsy perform	prior to death?	topsy findings available completion of cause of
_ ⊢ tare		25. Was case referred to medical		26 Place of Deat	1 ☐ Yes 2 th (Check only one	No 1 ☐ Yes	2 ₽No
VISION OT VITA Attending Physician: r death. ector: After this certific by the funeral director, i	To Be	examiner? 1 Yes 2 Hospital: 1 Inpatient 2 ER/O	utpatient 3 □ DOA O	thor		nce 6 ☐ Other (Spe	cify)
On OT dling Phys hh. After this of tuneral directions	on:	Natural 5 ☐ Pending (Month, Day, Year)		ork?	28d. Describe ho	w injury occurred	
DIVISION I or Attending after death. Director: After	icati	2 Accident investigation 3 Suicide 6 Could not be 28e Place of injury. At home, fi		□Yes 2□No	28f. Location (Str	reet and Number or Ru	ural Route Number,
DIV al or A safter I Direct d in by	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury · At home, for building, etc. (Specify)	,,		City or Town	State)	
DIVISIO To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the ti		29a. Certifier (Check only (Ch	e, death occurred at the	time, date and place y opinion, death occu	, and due to the ca	ause(s) and manner a	s stated. e to the cause(s)
the H thin 24 the F	Medical	one) and manner stated. 29b. Signature and title of certifier		nse number		d. Date signed (Mont	
5 ≥ 5 8		- Charles Lall Alexander		714	8	1/25/09	
		Sol Halle divine and the second	(Type, Print)		, 0,		12.000
		MICHAIZL PURIELL JHRUMO 31. Date filed (Month, Day, Year) 32/Registrar's Signature	- 4940 E	ASTORY A	VE BAL	TIMER M	11224
Sta Regist	ate rar	31. Date filed (Month, Day, Year) AUG 2 7 2009 32 Registrar's Signature	parked				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 10e, perFh g895 9/1/09 11 State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 11:58 AM SHAH HIMATLAL AUGUST 25 LILAVATI 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard HOWARD COUNT Columbia GENERAL HOSPITAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, April 23, 5. Social Security Number Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🔀 F India 83 214-57-5521 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ?7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, The Medical Erach mr. rust be rigitled at 1 ☐Yes 2 No **Funeral Director** Howard Elkridge Maryland 10g. Citizen of What Country? 10f. Zip Code 10**7 086**t and Number India 21075 7066 Ducketts Lane Apt. 104 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married SpecifyAsian Indian Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify. 2 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. em 27 is marked other than Own Home Homemaker 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be unk Reva Sakarchand Shah ဂ္ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10 Church Street, Courtland, New York 13045 permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tr. once. Amita Shah/ Daughter 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition August 27, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Baltimore, Maryland Metro Crematory, Inc. 21. Signature of Funoral Service Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc. Ella 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PNEUMONIA 2 DAYS /Medical Due to (or as a consequence of) Examiner ZDAYS SEPS IS Sequentially list conditions, if any, leading to immediate cause. Enter or serving Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner 5DAYS Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit URINARY TRACI INFECTION Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760 4 mounts Physician/Medical DECONDITIONING IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 🗖 No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ CORONAR 1 ☐ Yes 2 🕱 No 3 Probably 4 Unknown DISEASE been si Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒No THROMBOSIS 24a. Was an DEED VENIOUS s certificate has the irector, page 2 st autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral . Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation after death.

Director: Aft d in by the fur 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide within 24 hours after de To the Funeral Directo completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D50404 August 25, 2009 30. Name and address of per who completed cause of death (Item 23a) (Type, Print) COLUMBIA PKW MD 21044 LITTLE PATUXENT III 32. Registrar's Signatur 31. Date filed (Month, Day, Year) State AUG 2 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** :04 M BIOLIT Remard 08 5 2009 21 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) N/A Maryland Iniversit 9. Birthplace (State or Foreign Country) MD 5. Social Security Number . Age (In vrs. last birthday) **Funeral** 1 X M 2 □ F Months unk Director 59 08/25/2009 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d Inside City Limits show ral", or items 23a or 28a-f sho Baltimore MD N/A 1 Yes 2 □ No Director 10f. Zip Code 21215 10e. Street and Number 10g. Citizen of What Country? 5326 Nelson Ave. - Apt. USA Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Never Married 2 ☐ Married African Baltimore, Maryland 21215-0036 "natural", or If Yes, Give Year or Dates: 1 ☐ Yes 2 🔀 No ģ Specify. 3 Widowed 4 Divorced Ămerican Completed other traumatic event, the Medical 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) N/A than Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, Inc. In College (1-4or 5+) N/A 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bernard Spencer Latrice Morgan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Latrice Morgan/Mother 5326 Nelson Ave, Apt. 2, Baltimore, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 8/27/09 Hanover,MD Ardent Crematory 22. Name and Address of Facility Hari P. Close F.Svs, PA 21. Signature of Fune al Service Licenses 5126 Belair Rd, Balt., MD 21206-5105 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ilmonary Sequentially list conditions, Examiner if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the death certificate be executed <u>congenita</u> sician and burial-trans Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the as IF FEMALE: asn If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performed certificate 2 No 2 No 1 Myes 1 ☐ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred or Attending 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated.

State Registrar

31. Date filed (Month, Day, AUG 27 2009

bebe

Elias

29b. Signature and title of certifier

South Règistrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D00680*5*5

G5110

29d. Date signed (Month, Day, Year)

Baltimore MD 21201

August 25, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Harry Smith, Jr. August 24 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Golden Living Center Westminster Carroll Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 1 X M 2 □ F Months Days Hours 81 **Director** 30, 1927 Maryland 216-22-9232 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If then 27 is marked other than "natural" or the frainmain. 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1⊠Yes 2□No Directo Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 431 Cumming Court 21201 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 □ No If Yes, Give Year or Dates: 1946–49 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 XXNo Specify: Completed by 3 XWidowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 10 painter self-employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Harry Smith Eva Bowens 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leslie R. Barard/daughter Accokeek, MD 20607 14500 April St. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/28/2009 4 ☐ Donation 5 ☐ Other (Specify) Mt. Joy Cemetery Uniontown, MD Signature of Funeral Service 22. Name and Address of Facility Hartzler Funeral Home Union Bridge, MD 21791 6 E. Broadway 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 04 /Medical Due to (or as a consequence of): **Examiner** wooderated Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medical Examiner (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. if yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery Live birth 2 Fetal death 3 D Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe this certificate 1 ☐ Yes 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a, Certifier 1 🕳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier address of person who Johnh 333 MD Day 31. Date filed (Month, Year) 32. Registrar's State AUG 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 6:02 ETTA LOUISE SHACKELFORD /Medical 4a, Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death **Examiner** Frankin Square Hospi osedale Baltmore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 8~8~1921 Birthplace (State or Foreign Country) 6. Sex **Funeral** 7. Age (In yrs. last birthday) 1 □ M 2 🕱 F Director 88 178~16~1716 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shov Examinar must be notified at Director 1 ☐Yes 2 No Maryland Baltimore Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 9125 Avondale Rd. USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊡Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify: Specify: White ¥₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 yrs. College (1-4or 5+) N/A permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other thi any injury or other traumatic event, the once. Edgewood Arsenal Secretary Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elmer G. Torbert Nora Mobley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12509 Regwood Rd. Hydes, Md. 21082 Carol Willinghan (Daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State 8-28-2009 Moreland Memorial Pk. Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 21 ASSATAMOFSAFETAY1 Home 7401 Belair Rd. Baltimore, Md. 21236 23a. Part1. Enter the dise see or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ulmonary Immediate Cause (Final **Physician** tripolism disease or condition resulting in death) /Medical Due to (or as a cons quence of): Examiner Sequentially list conditions, any least gloring cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed s been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Ye ar 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 1 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation dea h. 1 ☐ Yes 2 ☐ No neral cirector / 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical

State

Registrar

29b. Signature and title of cortifier

Dr. Binh Nauven

death (Item 23a) (Type, Print)

D0065094

Drive Baltimore MD 21237

29d. Date signed (Month, Day, Year)

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 🛴 🖯 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician 9** 2:30 AM Hell thnie /Medical Town, or Location of Death 4c. County of Death **Examiner** BaHIMORE Year If Under 24 Hrs 8. Date of Birth (Month Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 💢 F Days Hours Min. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hjury or other traumatic event, the Medical Evantian must be notified anonge. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Raltimore Yes 2 No **Funeral Director** 10g. Citizen of What Country? Street and Nu 10f. Zip Code Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 □Yes 2 No Specify: Completed by 3 Widowed 4 Divorced 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired), Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ratinore, Maryland 21244 20a. Method of Disposition Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a by Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed IF FEMALE: 23c. if yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 3 Ectopic pregnancy Year Month Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 **Z**No 2 No 1 ☐ Yes 25. Was case referred to medicel examiner? 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 Yes 2 No 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 □ No 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The dical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical d manner stated. 29b. Signature

Registrar

State

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2009 2:22 P M Raymond Benjamin Singleton, Sr. August 24, /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Baltimore City 524 North Charles Street Apt. 312 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday.) **Funeral** Days Min. Months Yrs Maryland | July 8, 1943 218-40-8092 66 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-6 etc... any injury or other traumatic event, ILE Marter France. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1X Yes 2 □ No Baltimore City **Funeral Director** N/A Maryland 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 524 North Charles Street Apt. 312 United States 21201 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4X Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Monumental Supply Truck Driver 10 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edna Redmond Gilbert Singleton ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9 Blue Spire Circle Middle River, MD (Daughter) Malisa Gillum 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Hilltop Service Corp. 8/28/2009 Towson, Maryland 4 ☐ Donation 5 Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk,
7922 Wise Ave. Dundalk, Maryland 21. Signatule if Funeral Service Licenses Inc. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SCYI /Medical Due to (or as a consequence of) Examiner Eripher Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed Box 68760.0 and resulting in death) Last Due to (or as a consequence of): Physician/Medical phys the L IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown sate has been signed by the attendir page 2 should be detached for use. 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Day Month 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 1 ☐Yes 2 ☐No 1 ☐Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: Other: 4 ☐ Nursing Home 5 💆 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? Hospital or Attending 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐Yes 2 ☐No after death.

Director: Af
d in by the fur 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral 6 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar 3509

Eastern Ague Baltimore, Mary and

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

uhar

ukesh

Date filed (Month, Day, Year)

AUG 27 2009

MP

32 Registrar's Signature

within 2 To the complet

Melissa Brassell, MD 31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifie

32. Registrar's signatur

Assistant Medical Examiner

and manner stated

Diasig 30. Name and address of person who completed cause of death (Item 23a)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d Date signed (Month, Day, Year)

August 18, 2009

Jedical

Amend #11 state of Maryland 2 began of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Thomas Kenneth Barry 2009 9:05 A M August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Hospice 8. Date of Birth (Month, Day, Year) 6/8/1949 9. Birthplace (State or Foreign Country) Virginia If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 1 🔀 M 2 🗆 F 60 239-82-3052 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 K No MD Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21040 Burnley Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc 1 ☐ Yes 2 🛣 No If Yes, Give 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No Specify: Specify: White 3 Widewed 4 X Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Transportation Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen Margaret Ware Wade Howard Thomas 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1601 East F Street Lot 50, Torrington, WY 82240 Timothy Thomas/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/26/2009 4 X Donation 5 ☐ Other (Specify) Anatomy Gifts Registry | Hanover, Maryland 21. Signature Funeral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cerebrovasular Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence or). attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Coronary Arty Disease 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? Substance abuse 24a. Was an 1 Yes Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital æ examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural work?
1 Yes 2 No 5 Pending within 24 hours after death. To the Funeral Director; At 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Contifying Number Fraction on Table beat of my movined at the time date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifig 29c. License number 29d. Date signed (Month, Day, Year) R149194 rust 25, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) marian Grant 6701 N. Charles St. Touson, MD 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Mollie 1039 Troutman August 19 2001 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard County General Hospital Howard County columbia Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 1 □ M 020-14-2176 4-11-1920 Director 89 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Musical Exercites must be routiled at 1 ☐Yes 2 ☐No Director MD Howard Columbia 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number within 72 hours after death with 10621 Gramercy Place 21044 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes Give Specify. Black ģ 3 Midowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Mass Mutual Life Elementary/Secondary (0-12) College (1-4or 5+) Ins Co. Administration 12th grade N/A18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mollie Harrison Solomon B. Brown ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Carol A. TroutmaRaughter Gramercy Place Columbia, MD 21044 10621 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition N Burial 2 ☐ Cremation 3 ☐ Removal from State 8-27-2009 Springfield, Mass Oak Grove Cem 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March F/H East la wan 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Athroscleratic Coronary Vessel /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to for as a consequence of any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-tran and Due to (or as a consequence of) physician Physician/Medical as the attending p IF FEMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. I signed by the a d be detached for 1 ☐ Yes 2 X No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ò Vascular Accident 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been si , page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate Division of Vital 1 □ Yes 2 No 1 ☐ Yes 2 Mo director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🙀 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred al or Attending F safter death. I Director: After d in by the funera 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours a

To the Funeral C To the Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0053312 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

Michelle A Hengseler, MO

22. Registrar's Signature

5755

Cedar Lane, Columbia, MD 21044

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 12:45AM TALKIN MIGNON 24 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Sinai Hospital Baltimore Baltimore N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/04/1910 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Hours 1 □ M 2 🕽 F 213-38-9916 MD Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its invalies it is notified at 1 ☐ Yes 2 👿 No Director MD BALTIMORE BALTIMORE 10g. Citizen of What Country? 10e Street and Number 21208 725 MT. WILSON LANE USA Funeral Was Decedent Ever in U.S Armed Forces? 1 ∏Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2X No Specify: WHITE 21215-0036 Specify ģ 3 X Widowed 4 ☐ Divorced 1 and 2 should be filed within 72 hours Health and Mental Hygiene. em 27 is marked other than "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) SOLOMON SILVERMAN HANNAH KRAMER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) LINDA HIMMELRICH / DAUGHTER 11 ROLAND MEWS, BALTIMORE, MD 21210 Baltimore, 20b. Place of Disposition (Name of ARL TNGTON MAYYO ZUK place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State AMUNO CONGREGATION 4 ☐ Donation 5 ☐ Other (Specify) 08/26/2009 BALTIMORE, MD 22. Name and Address of Facility 21. Signature Funeral Service Licensee SOL LEVINSON & BROS., INC. TUCO 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Hypercapnesc /Medical Due to (or as a consequence of): Examiner Preumonie Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-transit ongush re Due to (or as a consequence of): Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown icate has been siç , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐ Yes 2 ☑ No 1 ☐Yes 2 ☑No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After t To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending 1 ☐Yes 2 ☐No investigation 2 Accident filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 5 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sineu HOS

State Registrar 32. Registra Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2009 10:33PM 24, Tarburton, Jr. August Frederick Н. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Co. 7521 Carson Avenue Berkshire Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Date of Birth (Month, Day, Year)
ept. 30,1954 5. Social Security Number 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Months Maryland Sept. 213-68-8200 Director 54 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f show traumatic event, the Middeal Exercities rount be notified at 1 □Yes 2 No Director Berkshire Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 21224 7521 Carson Avenue United States Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Enrice. Once. Black, White, etc. 1 Never Married 25 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ♣ No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 2 Years Law Enforcement 12 Years Baltimore County Police 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eunice Ludwig Frederick H. Tarburton, Sr. 2 19a. Informant's Name/Relationship (Type. Print) Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21224 Baltimore, Maryland Mrs. Kimberly D. Tarburton 7521 Carson Ave. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/27/2009 Oak Lawn Cemetery Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Harboza faul 7. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final 4 NONTHI **Physician** adero curcurena disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, learning to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to fur as a nunsecurine of Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 □Yes 2 □No 9 Unknown څ signed b be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 1 □ Yes 2 PNo 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 TYes 2 ₩ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 ☐Pending investigation 1-Natural death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D19714 sucreen 30. Name and address of person who completed cause Viea h (Italia 23a) (Type, Print) EASTERN AVE BALTIMOR MOZIZZY URTEIL HBVMC 4940

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registrar's Signature

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Madical Examinar must be notified at once. Baltimore, Maryland 21215-0036

> Physician /Medical **Examiner**

Division of Vital Records, P.O. Box 68760, や

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	State of Maryland / State of Maryland / State of Maryland /		irtment of H <i>rtificate of L</i>		and M	-	giene 2 Reg. No.	009	2748	
I	1. Decedent's Name (First, Middle, Last)					2. Date of De			3. Time of Death	
ı	Joseph John Vinci					Month AUGUS	Day	Year 2 (2) (2)	9 05:30A	
ĺ	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of	f Death	V - 112 ELE 112		unty of Death		
	Saint Joseph Medical Cente	7		T	OWS	οn		Bal	timore	
	5. Social Security Number 6. Sex 7. Age (In yrs. last bi	rthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 12/12	/1925	Cor	nplace (State or Foreig Intry) y I and	
ŀ	Usual Residence of Decedent									
	10a. State 10b. County 10c. City, Tow								10d. Inside City Limit 1 ☐ Yes 2 🛣 N	
	MD Baltimore White	Mar								
	10e. Street and Number		10f. Zip Code				10g. Citizen		intry?	
	6013 Loreley Beach Road	10.11	21162		. 0 (0	· · · · · · · · · · · · · · · · · · ·	U.S.A			
	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No	13. V	Vas Decedent of Hi f Yes, specify Cuba	n, Mexicar	gin? (Spe i, Puerto f	Rican, etc.)		Race - Amer Black, White		
	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates: WWII	1	□Yes 2XNo	Specify:			Sp	ecify:	White	
	15. Decedent's Education 16a		lent's Usual Occupa				16b. Kind o	of Business/I		
	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	`life. E	kind of work done of OO NOT use retired			ng				
,	Elementary/Secondary (0-12) College (1-4or 5+)	reig	ht Car In	spec:	tor		Rail	road		
	17. Father's Name (First, Middle, Last)			18. Mothe	er's Name	(First, Middle	Maiden Sur	name)		
	Samuel P. Vinci			Lena	a Cas	siniss	i			
	19a. Informant's Name/Relationship (Type. Print) 19	b. Mailin	g Address (Street a	nd Numb	er or Rura	l Route Numb	er, City or To	wn, State, Z	ip Code)	
			Loreley							
	20a. Method of Disposition 20b. Place of cemeter 1 □ Burial 2 □ Cremation 3 □ Removal from State 20b.	of Dispos ery, crem	sition (Name of natory or other place)	D	ate	20c. Locati	on - City or T	Town, State	
		<u>loo</u> d	Cemetery			/2009			Maryland	
	21. Signature of Funeral Service Licensee		. Name and Addres			Leonar Baltim				
resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Ener Unuenlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):										
	FFEMALE: 23c. If yes, outcome of pregnancy 23d. Date of the past 12 months? 1									
	Part II. Other significant conditions contributing to death but not resulting ACUTE ON CHRONIC RENAL					old tobacco use contribute to the cause of death? ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknow				
	CORONARY ARTERY DIS	EA	SE		24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2 No					
	25. Was case referred to medical examiner?				of Death	1 ☐ Yes (Check only o				
	1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/O		t 3 DOA Othe	4 🗆 14	rsing Hor	ne 5 ☐ Resi	dence 6	Other (Spec	cify)	
		Time of Injury arm, stre	M 1 🗆	rat ? ′es 2 □	No	28d. Describe 28f. Location (City or To	Street and N		ral Route Number,	
	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge and manner stated.									
	29b. Signature and title of certifier		29c. License				29d. Date si	igned (Month	1, Day, Year)	
	(Check only one) Medical Examiner: On the basis of examination a and manner stated.	(Type, I	29c. License D37 Print)	number	ath occurr		29d. Date si	ace, and due	to the cause(s)	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Sta Registr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 5:20 PM Wiley Sherman William 2009 HADASI /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Year If Under Hours Fri was 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 5. Social Security Number Age (In yrs. last birthday **Funeral** Months 1 X M 2 □ F 218-44-7109 61 Yrs 6-19-1948 N.C. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Department of Health and Mental Hygiene. Important: if item 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a liverified at 1 Yes 2 No Director MD N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2310 Robb Street 21218 S Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 TYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Black Specify: 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Baltimore City College (1-4or 5+) 3 year Elementary/Secondary (0-12) Deputy Sheriff 12th grade years Sheriff Dept 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Haywood William Wiley Emma Bradsher ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Wiley -Sister 1102 Orleans Stteet Apt 204 Balto, MD 21202 Linda 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest 9-2-2009 Owings, MD 4 ☐ Donation 5 ☐ Other (Specify) March East F/H 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause are each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** erem disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** ostridiu if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed burial-transit 201002105 and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) the detached 9 I Inknown d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗖 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy or Attending Physician: The certificate 2 No 1 ☐Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral c 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital

Division of Vital Records,

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Ancrman Wiley

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Downar

30. Name and address of person who completed caus of death (Item 23a) (Type, Print) Grawas

<u>000</u>

and manner stated.

32. Registrar's Signature 31. Date filed (Month, Day,

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Legistrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Reg. No. Decedent's Name (First, Middle, Last) Year

3. Time of Death

Physician /Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar", or items 23a or 28a-f show amy lighty or other traumatic event, it. If Alfall Examiner must be notified at

Maryland 21215-0036

Baltimore,

textores

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box

200 Timothy B Wright 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) HIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 6. Sex 1 X M 2 ☐ F Birthplace (State or Foreign Country) ge (In yrs. last birthday) Yrs 214-88-5201 45 12-31-1963 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Baltimore Gwynn Oak 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5525 Lexington Road 21207 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married 1 ☐Yes 2X No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Disabled Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles B. Wright Janice Beutelspacker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5525 Lexington Road Gwynn Oak, MD 21207 Brenda S. Wright 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Don(tion 5 ☐ Other (Specify) Atlantic Crematory 8-20-2009 Glen Burnie MD 22. Name and Address of Facility Ambrose Funeral Home Signatur If France Service Vices 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. W Approximate Interval Between Onset and Death Immediate Cause (Final FAILURE -IVER disease or condition resulting in death) Due to (or as a consequence of): COHOLIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). HEPATITIS Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Sargita Verna 124070 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VERMA900 Caton Ave., Baltimore, MD 21229

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 2009 19 /Medical THELMA WILSON 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 1 M 2 F Months Days Hours Min. 214-50-6644 60 11-19-1948 Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a. State X Yes 2 No Director TURNER STATION BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 USA 508 NEW PITTSBURG AVENUE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2x No Specify. Completed by Specify:BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) WINNER CO. SALES 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be YOUNG ELLA HERBERT SHARP ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 508 NEW PITTSBURG AVE., BALTO., MD 21222 MELVIN PARKER WILSON, SR/HUSBAND 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HOLLY HILLS CEM 8/31/09 MIDDLE RIVER, MD 21. Sign turn of Femeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H, INC 1701 LAURENS ST., BALTO., MD 21217 23a. Party Enter the disease, or complications that bused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a con-e n ence of): Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown was a autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 2 Accident 1 ☐ Yes 2 ☐ No Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-tran Division of Vital Records, P.O. Box 68760 attending physician for use as the buria certificate has been signed by the rector, page 2 should be detached funeral director, Atter iours after death.
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Funeral

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28a-f show

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natural", or items 23a

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permit. Pages 1 and 2 s Department of Health a Important: If item 27 Is any injury or other trat once.

Physician /Medical

Examiner

Pages 1 and 2 should be

or other traumatic event, the Medical Examiner must be notified at

the Maryland

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24 hours a the within 2

> State Registrar

29c. License number 1)36663

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

08/25/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Square Drue Baltimore Marylano

9000 Franklin 31. Date filed (Month, Day, Year) 82. Registrar's Signature

determined

4 Homicide

29b. Signature and title of certifier

29a. Certifier (Check only 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Marylan		artment of H <i>rtificate of L</i>			jiene _{eg. No.} 2010	0 271.01			
			1. Decedent's Name (First, Middle, Last)					2. Date of Deat	th	3. Time of Death			
	Physicia /Medic		PATRICIA ANN WILL	IAMS	Month AUGUS	009 4:23P M							
	Examin		4a. Facility Name (If not institution, give s Saint Joseph		Location of Death		Death altimore						
	Funeral Director		5. Social Security Number 6. Sex 216~36~9095	7. Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 30	(Year)	Birthplace (State or Foreign Country) Maryland			
	ס		Usual Residence of Decedent					001y 00	, 10 10 1				
	ırylan show	_	10a. State 10b. County		y, Town or Lo	imore Cour	. +.,			10d. Inside City Limits 1 □ Yes ※XNo			
	Ba-f	ecto	Maryland Baltimor	е	ТСУ		0. 0141						
	th with the 23a or 2	Funeral Directo	10e. Street and Number 2803 Upbridge Cou	rt Apt. A		10f. Zip Code	21234		10g. Citizen of What Country? USA				
36	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items of the marked other than "natural" or items of the marked other than the marked of the marked	by Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🖾 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cubar 1 □Yes XX No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- p Rican, etc.)	Black,	American Indian, White, etc. White			
ğ	2 hou	ted	15. Decedent's Educ	ation	16a. Dece	dent's Usual Occupa	ation		16b. Kind of Busin	ness/Industry			
21215-0036	filed within 72 Hygiene. other than "na ent, Ire Medient,	Completed	(Specify only highest grade Elementary/Secondary (0-12)		life.	kind of work done d DO NOT use retired;)	king	Johns Ho				
2	ed wil ygien ner th	Con	Elementary/Secondary (0-12)	College (1-4or 5+)	Med	ical Reco		(F) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Home Car				
Maryland	should be fill and Mental H s marked ott tumatic even	To Be	17. Father's Name (First, Middle, Last) William I. Cleary	,		Name (First, Middle, Maiden Surname) B. Smith							
lary	2 shou and N Is ma auma	, z	19a. Informant's Name/Relationship (Type		1	ng Address (Street a			_				
	and health m 27	8	William J. Cleary	<u> </u>		Township							
altimore,	iges 1 nt of H : If ite or ot		20a. Method of Disposition X⊠ Burial 2 □ Cremation 3 □ R	emoval from State		osition (Name of matory or other place	i		20c. Location - Ci				
<u>=</u>	it. Pa intmer intant injury	ŝ	4 Donation 5 Other (Specify)		-	eemer Cem		· · · · · · · · · · · · · · · · · · ·	Baltimor	e, Md.			
Ba	permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any injury or other traumatic e once.	5	21. Signature of uneral Service License	Vassahn	La 74	^{2. Name and Addres} Issahn Fun 101 Belair	eral Hom Rd. Bal	e timore,	Md. 2123	16			
			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on	or respiratory arr	rest,	Approximate Interval Between							
	Physician		Immediate Cause (Final disease or condition	RESPIRATO	RY FE	ILURE				Onset and Death			
ud	/Medical Examiner		resulting in death)	Due to (or as a consequence of): CONGESTIVE CARDIOMYOFATHY									
		-	Securifically list conditions bif any, leading to immediate	Due to (or as a consequence of):									
	uted 1 Insit	Examiner	cause. Enter Underlying Cause (Disease or injury	SEPTIC SH									
o,	exec an and ial-tra	Еха	that initiated events cresulting in death) Last	Due to (or as a consequ									
68760,	icate be executed physician and the burial-transit	dical		MULTIPLE	MYELO	MA							
0	death certifi e attending d for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of c	I death 3	☐ Ectopic pregnancy ☐ Other (specify)	/		23d. Date Monti				
s, P.	law requires that the as been signed by th 2 should be detache	by Pr	Part II. Other significant conditions con				en in Part I.	23e. Did to		ute to the cause of death?			
ecords,	w requir s been si should b			LINSUFF	-ICLE	NCY		1 □ Ye	es 2 No 3	☐ Probably 4 ☐ Unknown			
\mathbf{r}	The ate h	Completed	LACTIC ACI	-DOSIS				24a. Was a autops perform	med? pri	ere autopsy findings available or to completion of cause of ath? □Yes 2 KNo			
Ž	Physician: r this certifica ral director, p	Be	25. Was case referred to medical examiner?	ospital:		nt 3 🗆 DOA Othe	ar-	th (Check only or					
ō	Phy ratid	: To	1 ☐ Yes 2 ▼No 27. Manner of Death	28a. Date of Injury	28b. Time o	III 3 LI DOM	4 Li Nursing F		ence 6 Other ow injury occurred				
on	rding F th. : After s funera	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	Injury	of 28c. Injury Work M 1 🗆	? Yes 2 □ No		. ,				
Division of Vital	the Hospital or Attending hin 24 hours after death. the Funeral Director: After Tipletely filled in by the fune	Certification: T	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	reet, factory, office				or Rural Route Number,				
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical C		sician: To the best of my kno ner: On the basis of examina and manner stated.									
	To th within To th соттр	Me	29b. Signature and title of certifier		iw	29c. License	number	2	29d. Date signed ((Month, Day, Year)			
B			Kichard	Luthic	i ce u	D318	326		8-2	5-07			
			30. Name and address of person who co	mpleted cause of death (Item	n 23a) (Type,	Print)							
			RICHARD L LINTH	ICUM, M.D.	76.211	OSLER D	RIVE T	JWSON,	MARYLAN	ID 21204			
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Spna	Back	25							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 71,09 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 5:53 PM RIES August 19,2009 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) BALTIMORE N/A MARYLAND DOR ATIGROPH 8. Date of Birth (Month, Day, Year) Dec. 14,1935 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) West Virginia Days Min 1**X**□M 2□ F Yrs. 212-32-6814 73 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 No Edgemere Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21219 2552 North Snyder Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married Married 1 ∐Yes 2 🛣 No Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Raymond Metal Forklift Operator 6 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Virgie Harper Lewis Wood 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 2552 North Spyder Ave. Edgemere, MD 21219 19a. Informant's Name/Relationship (Type. Print) 2552 North Snyder Ave. Edgemere, MD Mrs. Mildred E. Wood (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem 9/22/2009 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature Juneral Service) 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. white 7922 Wise Ave. Dundalk, Maryland 21222 Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part . Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) FAILURE 10 years ONGESTIVE Due to (beas a consequence of) Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IC CCMAN C of delivery Day Year ute to the cause of death? Probably 4 🗍 Unknown ere autopsy findings available or to completion of cause of ath? 2 \No lYes

Physician /Medical **Examiner**

Physician

/Medical

Examiner

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Funeral

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Completed

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed burial-trans within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran Division of Vital Records, P.O. Box 68760,

Examiner by Physician/Medical Be Completed Medical Certification: To within 24 hours a

23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of Month
Part II. Other significant condition		23e. Did tobacco use contribe
Hypertension	end stage RENAL disease,	1 ☐ Yes 2 ☐ No 3
CORONARY	arthery disease,	24a. Was an 24b. We autopsy pric
AORTIC S	1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use of the underlying cause given in Part I. 23e. Did tobacco use of the underlying cause given in Part I. 23e. Did tobacco use of the underlying cause given in Part I. 24e. Was an autopsy performed? 1 Yes 2 No 24e. Was an autopsy performed? 1 Yes 2 No 25e. Place of Death (Check only one) 1 Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6	performed/ dea
25. Was case referred to medical	26. Place of Death (Check only one)
examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Home	5 ☐ Residence 6 ☐ Other
27. Manner of Death	28a, Date of Injury 28b, Time of 28c, Injury at 28c	d. Describe how injury occurred

(Specify) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Moretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

RES 0001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

South Hanover St. BALTIMORE, 3001

State Registrar

Nikita Pozderev MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature

the

 $MCCO14C17L\dot{1}$ Division of Vital Records, P.O. Box 68760,

		1 State	e of Marylan		artment of F	lealth and Me		000	0 271.0	
		Registrar		CE	Tillicate of I		Reg. N	0. 4. 4. 4	3. Time of Death	
Physicia	n	1. Decedent's Name (First, Middle, Last)				2	Month D August	ay Year		
/Medica			mans		4h City Town or	Logotion of Dooth		c. County of Dea		
Examine	er	4a. Facility Name (If not institution, give street and				Location of Death				
uneral		Upper Chesapeake H 5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday	Bel If Under 1 Year	If Under 24 Hrs. 8	. Date of Birth	Harfo	rthplace (State or Foreign	
irector		212-48-8344 1 M 2 X		Yrs.	Months Days	Hours Min.	(Month, Day, Yea 8 / 20 / 19	46	ouintry) MD	
		Usual Residence of Decedent				1				
Show	٦	10a. State 10b. County MD Harford	10c. City	, Town or L F:	dgewood				10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Wordel Eventhan routh by notified at once.	Funeral Director						10- (Citizen of What C		
be or	흅	10e. Street and Number 1951 Edgewater Dri	wo Ant	т	10f. Zip Code	040	Tog. C	USA	ountry !	
1s 23	era		Decedent Ever in U.S				fy Ves or No-	14. Race - Am	erican Indian	
iter iter	튑	Arme	ed Forces? Yes 2 No	J. 10.		ispanic Origin? (Speci an, Mexican, Puerto Ri	can, etc.)	Black, Whi	te, etc.	
o,"le	þ	If Ye	s, Give Tor Dates:		1 □ Yes 21X No	Specify:		Specify: V	Vhite	
atur icel i	Completed	15. Decedent's Education (Specify only highest grade comple		16a. Dec	edent's Usual Occup	ation	16b.	Kind of Business	s/Industry	
an "t	nple		ege (1-4or 5+)			during most of working t)				
t, th	ပ်	12		Te	acher's			Educati	ion	
d oth	m	17. Father's Name (First, Middle, Last) Howard Wasmer				18. Mother's Name (· ·		
narke natic	ှ									
7 Is n traun		19a. Informant's Name/Relationship (Type. Print Michael C. Youmans		1		and Number or Rural i ter Dr				
em 2	1	20a. Method of Disposition		<u> </u>	osition (Name of	Dat Dat		Location - City o	<u> </u>	
or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal	. a ce	emetery, cre	matory or other place crematory			anover,		
rtant njury	1	4 □ Donation 5 □ Other (Specify)	ļ.		2. Name and Addre		יוו כסס.	anover,	1.10	
any is		21. Signature of Funeral Service Licensee Dor	ota Marsha	all '	Marylar	nd Cremat				
		23a. Part 1. Enter the disease, or complications	that assessed the death	Do not or	Po Box	1413, Ba	ltimore	, MD 2	1203 Approximate	
	Exa									
phys the	gic	d								
been signed by the attending should be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		23d. Date of d Month	elivery Day Year					
ned b deta	by Pi	Part II. Other significant conditions contributing	en in Part I.	I. 23e. Did tobacco use contribute to the cause of death?						
ole ole		Acute renal for		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Únknow						
s bee	Completed				24a. Was an 24b. Were autopsy findings available					
ite has age 2 s	<u>E</u>			autopsy prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 Yes						
rtifica tor, p	Bec	25. Was case referred to medical				26. Place of Death (•		
direc		examiner? 1 ☐ Yes 2 ► No Hospital:	1 ☑ Inpatient 2 ☐	ER/Outpatie	ent 3 DOA Oth	er: 4 ☐ Nursing Home	e 5 ☐ Residence	6 ☐ Other (Sp	necify)	
fter th	Certification: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	Date of Injury (Month, Day, Year)	28b. Time Injury	of 28c. Injur Worl	y at 28	d. Describe how in	jury occurred		
or: A he fu	äti	2 ☐ Accident investigation			M 1 🗆	Yes 2 □No				
n by	Ě	dotarminad 28e. I	Place of Injury - At ho building, etc. <i>(Specif</i>)	me, farm, s	reet, factory, office	28	 Location (Street City or Town, Sta 		Rural Route Number,	
led i										
Fune tely fi	Medical	29a. Certifier 1 V Certifying Physician: 7 (Check only 2 ■ Medical Examiner: On	the basis of examinat	wledge, dea tion and/or	th occurred at the ti nvestigation, in my c	me, date and place, ar ppinion, death occurred	nd due to the cause If at the time, date a	e(s) and manner and place, and du	as stated. ue to the cause(s)	
To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Ned		manner stated.		29c, Licens	e number	00-1	Tata eignad /8/	oth Day Vocal	
20 =		29b. Signature and title of certifier)			3420	4	Date signed (Mor		
-			(レンり	J4 LU	AU	qust 23	2,4007	
		- put ami knain	`			•	. (
		30. Name and address of person who completed	cause of death (Item	23a) (Type	. Print)	KEDINE				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009 H:00 A.M AUGUST Charles Richard Adolphi 4c. County of Death 4a. Facility Name (If not institution, give street and number) CEEIL PERRY MARYLAND HEALIH CARE SYSTEM Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 4, 5. Social Security Number Days 1946 1**)** M 2 □ F 212-44-7639 July Maryland 63 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1X Yes 2 □ No Frederick Frederick Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5520 Jefferson Blvd. 21703 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Armed Forces: 1 X Yes 2 No If Yes, Give Year or Dates: 1 965-69 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify: 3 ☑ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) unknown unknown unknown unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unknown unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) V.A. Maryland Healthcare System, Perry Point, MD21904 Aime Saylor (Decedent Affairs) 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition 1 🕅 Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville, Maryland 08/17/09 4 ☐ Donation 5 ☐ Other (Specify) Veterans Cemetery 100/1//09 of ownstring, National 22. Name and Address of Facility
Lee A. Patterson & Son Funeral Home, P.A. ture of Funeral Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line. Approximate Interval Between Onget and Depth ENCEPHALOPATHY DUE TO SEVERE Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 □ No 3 Probably 4 Unknown

Physician /Medical **Examiner** Box 68760. physician certificate be

Physician

/Medical

Examiner

Director

Funeral

Completed

Be

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Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evaniner must be notified at

12 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r

permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau

CHARLES.

PHYSICIAN: ADOLPHI,

NAME KNOWN TO

Baltimore, Maryland 21215-0036

Exami use as the burial-tran Physician/Medical attending p the is been signed by the should be detached þ Completed s certificate has b lirector, page 2 s' Be After this c funeral dire Certification: To To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral

P.O.

Division of Vital Records,

									10,00			
									24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □ No		
25. Was case referred to medical							26	. Place of Dea	th (Check only one)			
examiner? 1 ☐ Yes 2 🛣			Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home							ne 5 Residence 6 Other (Specify)		
27. Manner of Deat 1 ☑ Natural 2 ☐ Accident	h 5 Pending investigation		a. Date of Injury (Month, Day, Year)	28b. Time of Injury	М		Injury at Work? 1 □ Yes	2 🗆 No	28d. Describe how injury	occurred		
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28	e. Place of Injury - At h building, etc. <i>(Speci</i>	nome, farm, stree	et, facto	ory, off	fice		28f. Location (Street and City or Town, State)	d Number or Rural Route Number,		
29a. Certifier (Check only one)		niner: (, and due to the cause(s) rred at the time, date and	and manner as stated. place, and due to the cause(s)		

29c. License number

29d. Date signed (Month, Day, Year)

0726926 completed cause of death (Item 23a) (Type, Print)
JEK, M.D. VA MARYLAND HEALTH EARE SYSTEM, PERRY POINT, MD 1901

Registrar DHMH 17 Rev 1/2001

State

Medical

29b. Signature and title of certifles

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** COLUMBUS ASHBY 0.8 2009 6:00 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges 4702 Addison Drive Oxon Hill If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days 1 JM 2 □ F Virginia 231-22-5335 81 8/23/1927 Director Usual Residence of Decedent 10d. Inside City Limits 10c City, Town or Location 10b. County r 28a-f show notified at 10a. State 1√2 Yes 2 □ No Director DC Washington death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number h and Mental Hygiene. 7 Is marked other than "natural", or Items 23a or traumatic event, the Medical Examiner must be r 20011 USA 5202 Kansas Avenue Funeral Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 11 Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Specify: Black If Yes, Give Year or Dates: 1 ☐ Yes 為☐XNo Baltimore, Maryland 21215-0036 Specify: þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Chemist Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Thomas Ashby Lucy Wallace 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Richard Ashby/ Son 410 Clairborne St., Upper Marlboro, MD 20774 of Health a Department of Health Important: If Item 27 any injury or other tr 20b. Place of Disposition (Name of Ftemperary crematory or other place)
Ft. Lincoln
emetery 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/17/2009 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Greene 21. Signature of Funeral Service Licensee Funeral Home 814 Franklin St., Alexandria, VA 22314 nelson & 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) WK DEHYDRATION **Physician** /Medical Due to (or as a consequence of) Examiner DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine PARKISONS the Hospital or Attending Physician: The law requires that the death certificate be executed DISSAC physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) the a 9□Unknown 9 Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death (Month, Day Year) Injury 1 ☑ Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

BJ

State Registrar 29b. Signature and title of certifie

2009 Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

priero

29c. License number

2100 w Pennsylvania Ave NW Washingto

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 3. Time of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year 2000 1220 PM **Physician** 08 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimare C.C Marykir Baltimore UNIVERSITY Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days **Funeral** Months Hours Cote D'ivoire 1 □ M 2 🖼 F Jan 18 1955 54 219-73-9380 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10b. County 10a. State show 1 Syes 2 No ir than "natural", or items 23a or 28a-f sho Director Silver Spring Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Cote D'Ivoire 20902 2306 Glenmont Circle #201 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: Black 1 ☐ Yes 21 No þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 3 years and Mental Hygiene. Elementary/Secondary (0-12) Self-employed Business Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if item 27 is marked oth any injury or other traumatic event sone. Be Meleme Nomel David Adou ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20902 19a. Informant's Name/Relationship (Type. Print) 2306 Glenmont Circle, #201 Silver Spring, MD Sonia Begnana/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Aug 22 2009 Silver Spring Gate of Heaven 4 ☐ Donation 5 ☐ Other (Specify) J.B. Jenkins Funeral Home 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 7474 Landover Road, Landover, MD 20785 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23h Was decedent pregnant Live birth 2 Fetal death 3 🗌 Ectopic pregnancy Month Year Day in the past 12 months? been signed by the atte should be detached for Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed' 2 🗆 No 2 1 No 1 □Yes 1 ☐ Yes certificate 26. Place of Death (Check only one) 25. Was case referred to medical the funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 Inpatient Certification: To this 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b Time of 28c. Injury at Work? 27. Manner of Death After Injury 1 M Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director; 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide completely filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year)

State

Baltimore, Maryland 21215-0036

29b. Signature and title of certifier

South

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

29c. License number

mo aracl

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Codi Nicole Alexander 5:44 pm^M 10 2009 August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🗓 F 224-69-7746 16 June 24,1993 Director Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show be notified at 1 ☐ Yes 2 ▼No Director MDMontgomery Gaithersburg 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a or 3 Country Woods Court 20878 United States traumatic event, the Medical Examinar must Funeral items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 72 hours after 1 Never Married 2 Married Specify: Multi Baltimore, Maryland 21215-0036 0 1 ☐ Yes 2 🛛 No Specify. ≥ 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7/s th and Mental Hygiene.
7 is marked other than "n. Elementary/Secondary (0-12) High School College (1-4or 5+) Student Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bruce A. Alexander Lisa M. Polak Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a Lisa M. Polak/ Mother 3 Country Woods Court, Gaithersburg, MD 20878 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Rose of Lima Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it any injury or conce. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State August 2009 14, Gaithersburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service L center DeVol Funeral HOme, 10 East Deer Park Drive, Gaithersburg, MD 20877 MUCE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Intra Cerebral Bleed /Medical DME Due to (or as a consequence of) Examiner Status Post Bike Accident Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed Due to (or as a consequence of) inding physician a Box 68760, J Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery atter for u 3 Ectopic pregnancy Day Year Month 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a o 9 Unknown 9 Unknown 9 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 perform certificate 1 ☐ Yes 2 ☐ No 1 □Yes 2XNo 25. Was case referred to medical director 26. Place of Death (Check only one) Be examiner? 1 XYes €XNe Hospital: 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28d. Describe how injury occurred Division Hospital or Attending 1 ☐ Natural 2 🛛 Accident 5 Pending pedestrian AUD 5 2009 1500 M 1 □Yes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Investigation 3 ☐ Suicide 6 Could not be determined ace of Injury - At home, farm, street, factory, office uilding, etc. (Specify) 28f. Location (Street and Number of Bural Route Number) City or Town, State) 4 Homicide Stree

Sam E. i. Wur, Gathery fur

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 23044 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road; Bethesda, MD 20814 Said Daee, M.D. 31. Date filed (Month, Day, Year) 37. Registrar's Signature State AUG 13 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year 3:05P M TULL BRADSHAW ROLLINS 2009 /Medical Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner icomico at Birthplace (State or Foreign Country) If Under 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 X M 2 □ F Hours Min 215-20-0365 87 Director May 15, 1922 Maryland Usual Residence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiens. important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It. w. dich Exa. intriust be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Wicomico Directo Maryland Hebron 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21830 7328 Levin Dashiell Road U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status 1 ☑Yes 2 ☐ If Yes, Give Year or Dates: 2 □ No World 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🙀 No Specify: ð Specify: White 3 Widowed 4 Divorced War II Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager Shoe Store 12 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Hezekiah Bradshaw Florence Tull 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7328 Levin Dashiell Rd. - Hebron, MD Lucille H. Bradshaw (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🖾 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sunnyridge Memorial Park | 8/15/09 Crisfield, MD nature biner berne lice ee Robert H. Bradshaw Jr. 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PARKINSON **Physician** SRASR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): sician and burial-transit death certificate be executed Exami Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown ģ s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy perform 1 □ Yes 1 ☐ Yes Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 1 No Of Bother (Specify) HOSPICE Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation al or Attendi s after death. Il Director: A death. 1 ☐ Yes 2 🗌 No filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Division of Vital Records, within 24 hours a To the Hospital completely

> 31. Date filed (Month, Day, Year) 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

(Check only one)

29b. Signature and litle of certifier

Hulson

Box 1737

09-06569

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene James Brown 1- For State Certificate of Death Rea. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day August 22, 2009 0445 hrs Medical Examiner James Brown 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Howard Columbia 6336 Cedar Lane #179B 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number **Funeral** Foreign Country) Scotland Days Hours Min Months Director 9/14/1917 91 019-07-976 1 XM 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County Yes 2 X No Columbia MD Howard after death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 21044 6336 Cedar Lane Apt 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 Never Married 2 Married 1 X Yes 2 f Yes, Give Year Specify: White Widowed Divorced Yes 2 X No specify: 2 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) permit. Pages 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n Elementary/Secondary (0-12) f other than "the Medical F MD 21215-0036 National Parks Draftsman 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Christina Baillie event, Be <u>James Brown</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21044 11808 Blue February Way, Columbia, MD Nancy Koza Niece 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, crematory or other place) or other Burial 2 XCremation Removal from State 8/24/2009 Hanover, MD Ardent Cremation Donation 5 Other Spealing 22. Name and Address of Facility Harry H. Witzke's Family FII, Inc 21. Signatur Coll uneral Service Licenses M01411 Columbia Pike, Ellicott City, 4112 01d23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Inter **Physician** Between Onset and /Medical Death Head injury Immediate Cause (Final disease **T**xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): s been signed by the attending physician and should be detached for use as the burial - transit The law requires that the death certificate be executed Physician/Medical 23a,PII,27,28a-f,perME, g894 8/28/09 TT X UNPENDED AMENDED Box 68760 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 3b. Was decedent pregnant in the 3 Ectopic pregnancy Month Year Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 V No 3 Probably 4 Unknown þ Hypertension; chronic obstructive pulmonary Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of disease autopsy death? this certificate has performed? 2 No Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Other, Residence 6 V Other: Scene Nursing Home 5 Inpatient 2 ER/Outpatient 3 2 1 ✔ Yes No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day,Year After 28b. Time of Injury 27. Manner of Death Certification: Yes 2 X No subject assaulted Natural Director: 4:09 8/17/09 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 0336 Cedar Lane 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) (nursing outside residence determined olumbia, MD4 X 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie August 22, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Jack Titus MD Deputy Chief Medical Examiner 31. Date filed (Mon. istrar's Signature State knews Registra

09-06260 Michael Burnette

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b State of Mary 1390/ Department of Health and Mental Hygiene

		For State Certificate eqistrar	of Death	Reg.	No.	10 0750
Physician	1/	. Decedent's Name (First, Middle,Last)		Date of Death Month Date	ay Year	3. Time of Death 1936 hrs
Medical Examine		Michael Burnette	Late City Town and position of Dooth	Month Da August 10, 2	4c. County of Death	19301113
	ľ	la. Facility Name (if not institution, give street and number) Prince George's Hospital Center	4b. City, Town, or Location of Death Cheverly		Prince George	's
	٩,	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs	8. Date of Birth (MM/DD/YYYY) 9. Birt	
Funeral Director	,	F70 70 0F(0	Months Days Hours Min.		Foreig	n to)
Birottor	L	1 W 2 1 3 0	rs.	12/02/1	.932	DC DC
å	-	Usual Residence of Decedent 10b. County 10c. City, Town or Lo.	cation			10d. Inside City Limits
- Ice wa		DC	Washington			1 X Yes 2 No
Varyland 28a-f show any 1 at once.	뢍	ince. Street and Number	10f. Zip Code	10g.	Citizen of What Cour	ntry?
or 28	Director	1503 Pennsylvania Ave. SE	20005		United	Ctataa
vith the s 23a e noti		11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp	pecify Yes or No-	14. Race - Ameri	can Indian, Black,
death with the Maryland or items 23a or 28a-f sho must be notified at once.	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No	f Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.]
	by F	Widowed 4 X Divorced If Yes, Give Year or Dates:	Yes 2 X No specify:		Specify: B1	
		15. Decedent's Education (Specify only highest grade completed) 16a. Dece	dent's Usual Occupation (Give kind of value) most of working life. DO NOT use reti		6b. Kind of Business/I	ndustry
6 n 72 h	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	omputer Specialis	- 1	C-15 E	.1
5-0036 led within 72 Hygiene. I other than "	틹	17. Father's Name (First, Middle, Last)	•	e (First, Middle, Mai	Se1f-Em	proyed
filed valued of the filed value of the filed of the fit, the filed	Š B				Mashington	
6 2 9 2 7	요 으	Booker T. Burnette 19a. Informant's Name/Relationship (Type, Print) 19b. Ma	ling Address (Street and Number or I			, Zip Code)
MD 21 d 2 should 1 th and Mer n 27 is man		LaDawn Doswell/ Daughter 12	911 Broadmore Rd.	Silver S	Spring, Md	. 20904
E E E E	Ī		position (Name of cemetery,		20c. Location - City or	
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other t	V	The state of the s	PherMen.CemeteryAug - Lincoln	2009	Suitland Brentwood	
altir mit. P partme oortai	1	4 Donation 5 Other Specify: 21 Signature of Fundal Service censee 2	2. Name and Address of Facility Ste	wart Fun	eral Home,	Inc.
iji ji ji ji ji ji			001 Benning Rd. N			20019
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not ent failure. List only one cause on each line.	er the mode of dying, such as cardiac	or respiratory arrest	t, shock, or heart	Approximate Interval Between Onset and
Medical xaminer		Immediate Cause (Final disease a. Gunshot Wounds (2) to Head ar	nd Back			Death
	-	or condition resulting in death) Due to (or as a consequence of):				
	힐	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	Examiner	C. Due to (or as a consequence of):				
rted 1 ansit		events resulting in death) Last Due to (or as a consequence or):				1
760, icate be executed physician and the burial - transit	Medical	UNPENDED AMENDED				
760, icate be physicate buri	Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliver	у
687 ertific ding p	<u></u>	23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pregn	ancy	Month	Day Year
Box 687 e death certification of the attending of the astending of the attending of the asset of	sici	4 Pregnant at time of death 5 Unknown g Unknown	Other (Specify)			
C. B. the de by the sched is	Physicia	Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
, P.O. ires that the signed by	6			1 Yes	2 V No 3 Pro	bably 4 Unknown
ords, w require	stec			24a. Was ar		utopsy findings available completion of cause of
COC law I has b	Completed			autops perform 1 ✓ Yes 2	ned? death?	
tal Rectan; The certificate ector, page	ខិ	25. Was case referred to medical	26.Place of Death (Check		No 1 Y	es 2 NO
Vital Recc ysiclan; The lav his certificate ha director, page 2	Be	examiner? Hospital: Inneticat 2 PR/Outpe	Other	-	Residence 6 Other	er:
1 of V ding Phy After th funeral d	음	27 Manner of Death 28a Date of Injury 28b. Time			ow injury occurred	
Ivision of Vital Records, a flet death. The law require safet death. I bir-ctor: After this certificate has been sind in ty the funeral director, page 2 should be.	틸	Natural 5 Pending FOUND: Day,Year) FOUND 1829 hrs	1 163 2 4 140	Subject shot		
/isi	fica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm,		28f. Location (St or Town, Sta		ural Route Number, City
Livision Hospital or Attendi 24 hours after death. Funeral Director;	Certification:	4 V Homicide determined (Specify) Residence		1503 pennsylva	ania Avenue SE, W	asington DC,
Hosp 24 hosp Funder Fun		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death of Check only	ccurred at the time, date and place, an	nd due to the cause	(s) and manner as sta	ited.
Livision of Vital Records, P.O. Box 68760, within 24 hours after death. To the Inspiral or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in (y the funeral director, page 2 should be detached for use as the burial - transit.	Medical	one) 2 Medical Examiner: On the basis of examination and/or invessing and manner stated.		at the time, date a		
	Σ	29b. Signature and title of certifier	29c. License number		29d. Date signed (M August 11, 200	
		my wines	O.C.M.E.		August 11, 200	
R3	0)	30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn S	treet, Baltimore, MD 21201			
		21 Date filed (Manth Day Veer) 29 Registrar's Signature	arou, Daramore, IVID 2 1201			
Sta Registi		AUG 1 4 2009 Denne B. Jane				